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State/Territory Name: Texas

State Plan Amendment (SPA) #: 14-42 NIRT

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

**Financial Management Group**

JUN 03 2015

Ms. Kay Ghahremani
State Medicaid/CHIP Director
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

RE: TN 14-42

Dear Ms. Ghahremani:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-42. This amendment revises the methodology for the distribution of Disproportionate Share Hospitals (DSH) reimbursements and revises the methodology for calculating hospital specific limits.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A.

Based upon the information provided by the State, Medicaid State plan amendment 14-42 is approved effective September 1, 2014. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

[redacted]

Timothy Hill
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**
**FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: **14-042**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **September 1, 2014**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
**Section 1923 of the Social Security Act**

7. FEDERAL BUDGET IMPACT: **SEE ATTACHMENT**
a. **FFY 2014** **$0**
b. **FFY 2015** **$0**
c. **FFY 2016** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
**SEE ATTACHMENT TO BLOCKS 8 & 9**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
**SEE ATTACHMENT TO BLOCKS 8 & 9**

10. SUBJECT OF AMENDMENT:
**The proposed amendment revises the way that the State's disproportionate share hospital allotment is distributed among eligible hospitals.**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
**Kay Ghahremani**

14. TITLE:
**State Medicaid Director**

15. DATE SUBMITTED:
**September 30, 2014**

16. RETURN TO:
**Kay Ghahremani**
**State Medicaid Director**
**Post Office Box 13247, MC: H-100**
**Austin, Texas 78711**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 9-30-2014

18. DATE APPROVED: JUN 03 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
9-1-2014

20. SIGNATURE:
[redacted]

21. TYPED NAME:
Kristin FAN

22. TITLE:
Deputy Director, FMG

23. REMARKS:

FORM CMS – 179 (07-92)

**Attachment to Block 7 of CMS Form 179**

**Transmittal Number 14-042**

| | Total Fiscal Impact | Federal | State |
|---|---|---|---|
| **FFY 2014** | $0 | $0 | $0 |
| **FFY 2015** | $0 | $0 | $0 |
| **FFY 2016** | $0 | $0 | $0 |

The proposed amendment will not impact the annual federal allocations to Texas for the disproportionate share hospital program.

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**Attachment to Blocks 8 & 9 of CMS Form 179**

**Transmittal Number 14-042**

| **Number of the Plan Section or Attachment** | **Number of the Superseded Plan Section or Attachment** |
|---|---|
| Appendix 1 to Attachment 4.19-A | Appendix 1 to Attachment 4.19-A |
| Page 1 | Page 1 (TN 13-042) |
| Page 4 | Page 4 (TN 13-042) |
| Page 5 | Page 5 (TN 13-042) |
| Page 6 | Page 6 (TN 13-042) |
| Page 7 | Page 7 (TN 13-042) |
| Page 8 | Page 8 (TN 13-042) |
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| Page 22 | Page 22 (TN 13-042) |
| Page 23 | Page 23 (TN 13-042) |
| Page 24 | Page 24 (TN 13-042) |
| Page 25 | Page 25 (TN 13-042) |
| Page 26 | Page 26 (TN 13-042) |
| Page 27 | N/A – New Page |
| Page 28 | N/A – New Page |
| Page 29 | N/A – New Page |

State: Texas
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**Disproportionate Share Hospital (DSH) Reimbursement Methodology**

(a) Introduction. Hospitals participating in the Texas Medicaid program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for reimbursement from the disproportionate share hospital (DSH) fund. HHSC will establish each hospital's eligibility for and amount of reimbursement using the methodology described in this appendix.

(b) Definitions.

(1) Adjudicated claim – A hospital claim for payment for a covered Medicaid service that is paid or adjusted by HHSC or another payer.

(2) Available DSH funds – The annual federal DSH allotment of funds that may be reimbursed to all DSH-eligible providers.

(3) Bad debt – A debt arising when there is nonpayment on behalf of an individual who has third-party coverage.

(4) Centers for Medicare & Medicaid Services (CMS) – The federal agency within the United States Department of Health and Human Services responsible for overseeing and directing Medicare and Medicaid.

(5) Charity care – The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to indigent individuals, either directly or through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

(6) Charity charges – Total amount of hospital charges for inpatient and outpatient services attributed to charity care in a DSH data year. These charges do not include bad debt charges, contractual allowances, or discounts given to other legally liable third-party payers.

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**
**Definitions (continued)**

(23) Low-income utilization rate – A ratio calculated as described in subsection (c)(2) that represents a hospital's volume of inpatient charity care relative to total inpatient services.

(24) Mean Medicaid inpatient utilization rate – The average of Medicaid inpatient utilization rates for all hospitals that have received a Medicaid payment for an inpatient claim, other than a claim for a dually eligible patient, that was adjudicated during the relevant DSH data year.

(25) Medicaid contractor – Fiscal agents and managed care organizations with which HHSC contracts to process data related to the Medicaid program.

(26) Medicaid cost-to-charge ratio (inpatient and outpatient) – A Medicaid cost report derived cost center ratio calculated for each ancillary cost center that covers all applicable hospital costs and charges relating to inpatient and outpatient care for that cost center. This ratio is used in calculating the hospital-specific limit and does not distinguish between payer types such as Medicare, Medicaid, or private pay.

(27) Medicaid cost report – *Hospital and Hospital Health Care Complex Cost Report*, also known as the Medicare cost report.

(28) Medicaid hospital – A hospital meeting the qualifications to participate in the Texas Medicaid program, as determined by the agency listed on page 43 of the basic state plan (relating to provider participation requirements).

(29) Medicaid inpatient utilization rate – A ratio calculated as described in (c)(1) that represents a hospital's volume of Medicaid inpatient services relative to total inpatient services.

(30) MSA – Metropolitan Statistical Area as defined by the United States Office of Management and Budget. MSAs with populations greater than or equal to 137,000, according to the most recent decennial census, are considered "the largest MSAs."

(31) Non-urban public hospital – A rural public-financed hospital, as defined in (b)(39), or a hospital owned and operated by a non-state governmental entity other than hospitals in Urban public hospital – Class one or Urban public hospital – Class two.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**
**Definitions (continued)**

(32) Obstetrical services – The medical care of a woman during pregnancy, delivery, and the post-partum period provided at the hospital listed on the DSH application.

(33) Outpatient charges – Amount of gross outpatient charges related to the applicable DSH data year and used in the calculation of the hospital specific limit.

(34) PMSA – Primary Metropolitan Statistical Area as defined by the United States Office of Management and Budget.

(35) Program year – The 12-month period beginning October 1 and ending September 30.

(36) Public funds – Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(37) Ratio of cost-to-charges (inpatient only) – A ratio that covers all applicable hospital costs and charges relating to inpatient care. This ratio does not distinguish between payer types such as Medicare, Medicaid, or private pay.

(38) Rural public hospital – A hospital owned or operated by a non-state governmental entity that is located in a county with 500,000 or fewer persons, based on the most recent decennial census.

(39) Rural public-financed hospital – A non-state hospital operating under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county with 500,000 or fewer persons, based on the most recent decennial census.

(40) State chest hospital – A state-owned public health facility operated by the Department of State Health Services and designated for the care and treatment of patients with tuberculosis.

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**
**Definitions (continued)**

(41) State-owned teaching hospital – A hospital owned and operated by a state university or other state agency.

(42) The waiver – The Texas Healthcare Transformation and Quality Improvement Program, a Medicaid demonstration waiver under §1115 of the Social Security Act that was approved by CMS on December 12, 2011.

(43) Third-party coverage – Creditable insurance coverage consistent with the definitions in 45 Code of Federal Regulations (CFR) Parts 144 and 146, or coverage based on a legally liable third-party payer.

(44) Total Medicaid inpatient days – Total number of inpatient days based on adjudicated claims data for covered services for the relevant DSH data year.

(A) The term includes:
- (i) Medicaid-eligible days of care adjudicated by managed care organizations;
- (ii) days that were denied payment for spell-of-illness limitations;
- (iii) days attributable to individuals eligible for Medicaid in other states, including dually eligible patients;
- (iv) days with adjudicated dates during the period; and
- (v) days for dually eligible patients for purposes of the calculation in (c)(1).

(B) The term excludes:
- (i) days attributable to Medicaid-eligible patients ages 21 through 64 in an IMD;
- (ii) days denied for late filing and other reasons; and
- (iii) days for dually eligible patients for purposes of the calculation in (c)(3) and (g)(4).

(45) Total Medicaid inpatient hospital payments – Total amount of Medicaid funds that a hospital received for adjudicated claims for covered inpatient services during the DSH data year. The term includes payments that the

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**
**Definitions (continued)**

hospital received:

(A) for covered inpatient services from managed care organizations; and

(B) for patients eligible for Medicaid in other states.

(46) Total state and local payments – Total amount of state and local payments that a hospital received for inpatient and outpatient care during the DSH data year. The term includes payments under state and local programs that are funded entirely with state general revenue funds and state or local tax funds. The term excludes payment sources that include federal dollars and contractual discounts and allowances.

(47) Uncompensated-care waiver payments – Payments to hospitals participating in the waiver that are intended to defray the uncompensated costs of eligible services provided to eligible individuals.

(48) Uninsured cost – The cost to a hospital of providing inpatient and outpatient hospital services to uninsured patients as defined by CMS.

(49) Urban public hospital – Any of the non-state urban public hospitals listed in (b)(50) or (b)(51).

(50) Urban public hospital – Class one – A hospital that is operated by or under a lease contract with one of the following non-state government entities: the Dallas County Hospital District, the El Paso County Hospital District, the Harris County Hospital District, the Tarrant County Hospital District, the Travis County Healthcare District, or the University Health System of Bexar County. A hospital's classification as an Urban public hospital – Class one is not subject to change.

(51) Urban public hospital – Class two – A hospital that is operated by or under a lease contract with one of the following non-state government entities: the Ector County Hospital District or the Lubbock County Hospital District. A hospital's classification as an Urban public hospital – Class two is not subject to change.

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**
**Qualification**

(c) Qualification. For each DSH program year, applicants must meet at least one of the following qualification criteria, which are determined using information from a hospital's application, from HHSC, or from HHSC's Medicaid contractors, as specified by HHSC:

(1) Medicaid inpatient utilization rate. A hospital's inpatient utilization rate is calculated by dividing the hospital's total Medicaid inpatient days by its total inpatient census days for the DSH data year.

(A) A hospital located outside an MSA or PMSA must have a Medicaid inpatient utilization rate greater than the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

(B) A hospital located inside an MSA or PMSA must have a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

(2) Low-income utilization rate. A hospital must have a low-income utilization rate greater than 25 percent.

(A) The low-income utilization rate is the sum (expressed as a percentage) of the fractions calculated in (c)(2)(A)(i) and (ii):

(i) The sum of the total Medicaid inpatient hospital payments and the total state and local payments paid to the hospital for inpatient care in the DSH data year, divided by a hospital's gross inpatient revenue multiplied by the hospital's ratio of cost-to-charges (inpatient only) for the same period: (total Medicaid inpatient hospital payments + total state and local payments)/(gross inpatient revenue x ratio of costs to charges (inpatient only)).

(ii) Inpatient charity charges in the DSH data year minus the amount of payments for inpatient hospital services received directly from state and local governments, excluding all Medicaid payments, in the DSH data year, divided by the gross inpatient revenue in the same period: (total inpatient charity charges – total state and local payments)/gross inpatient revenue).

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**
**Qualification (continued)**

(B) HHSC will determine the ratio of cost-to-charges (inpatient only) by using information from the appropriate worksheets of each hospital's Medicaid cost report or reports that correspond to the DSH data year. In the absence of a Medicaid cost report for that period, HHSC will use the latest available submitted Medicaid cost report or reports.

(3) Total Medicaid inpatient days.

(A) A hospital must have total Medicaid inpatient days at least one standard deviation above the mean total Medicaid inpatient days for all hospitals participating in the Medicaid program, except;

(B) A hospital in a county with a population of 290,000 persons or fewer, according to the most recent decennial census, must have total Medicaid inpatient days at least 70 percent of the sum of the mean total Medicaid inpatient days for all hospitals in this subset plus one standard deviation above that mean.

(C) Days for dually eligible patients are not included in the calculation of total Medicaid inpatient days under (c)(3).

(4) Children's hospitals, state-owned teaching hospitals, and state chest hospitals. Children's hospitals, state-owned teaching hospitals, and state chest hospitals that do not otherwise qualify as disproportionate share hospitals will be deemed disproportionate share hospitals.

(5) Merged hospitals. HHSC will aggregate the data used to determine qualification under this subsection from the merged hospitals to determine whether the single Medicaid provider that results from the merger qualifies as a Medicaid disproportionate share hospital.

(6) Hospitals that held a single Medicaid provider number during the DSH data year, but later added one or more Medicaid provider numbers. Upon request, HHSC will apportion the Medicaid DSH funding determination attributable to a hospital that held a single Medicaid provider number during the DSH data year (data year hospital), but subsequently added one or more Medicaid provider numbers (new program year hospital(s)) between the data year hospital and its associated new program year

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**
**Conditions of participation (continued)**

(3) Trauma system.

(A) The hospital must be in active pursuit of designation or have obtained a trauma facility designation as defined in the Texas Health and Safety Code. A hospital that has obtained its trauma facility designation must maintain that designation for the entire DSH program year.

(B) HHSC will receive an annual report from the Office of EMS/Trauma Systems Coordination regarding hospital participation in regional trauma system development, application for trauma facility designation, and trauma facility designation or active pursuit of designation status before final qualification determination for interim DSH payments. HHSC will use this report to confirm compliance with this condition of participation by a hospital applying for DSH funds.

(4) Maintenance of local funding effort. A hospital district in one of the State's largest MSAs or in a PMSA must not reduce local tax revenues to its associated hospitals as a result of disproportionate share funds received by the hospital. For this provision to apply, the hospital must have more than 250 licensed beds.

(5) Retention of and access to records. A hospital must retain and make available to HHSC records and accounting systems related to DSH data for at least five years from the end of each DSH program year in which the hospital qualifies or until an open audit is completed, whichever is later.

(6) Compliance with audit requirements. A hospital must agree to comply with the audit requirements described in (i).

(7) Merged hospitals. If HHSC receives documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, the merged entity must meet all conditions of participation. If HHSC does not receive the documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, any proposed merging hospitals that are receiving DSH payments must continue to meet all conditions of participation as individual hospitals to

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**
**Calculating a hospital-specific limit (continued)**

(II) State and local payments to hospitals for indigent care are not included as payments made by or on behalf of uninsured patients.

(A) Medicaid charges and payments.

(i) HHSC will request from its Medicaid contractors the inpatient and outpatient charge and payment data for claims for services provided to Medicaid-enrolled individuals that are adjudicated during the DSH data year for all active Medicaid participating hospitals.

(I) The requested data includes but is not limited to:

(-a-) Claims associated with the care of dually eligible patients, including Medicare charges and payments;

(-b-) Claims or portions of claims that were not paid because they exceeded the spell-of-illness limitation; and

(-c-) Claims for which the hospital received payment from a third-party payor for a Medicaid-enrolled patient.

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**
**Calculating a hospital-specific limit (continued)**

(1) Final hospital-specific limit.

(A) HHSC will calculate the individual components of a hospital's final hospital-specific limit using the calculation set out in (e)(1)(A)-(D), except that HHSC will:

(i) Use information from the hospital's Medicaid cost report(s) that cover the program year and from cost settlement payment or recoupment amounts attributable to the program year for the calculations described in (e)(1)(C)(ii)(I) and (e)(1)(C)(iii)(I). If a hospital has two or more Medicaid cost reports that cover the program year, the data from each cost report will be pro-rated based on the number of months from each cost report period that fall within the program year;

(ii) Include supplemental payments (including upper payment limit payments) and uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributable to the hospital for the program year when calculating the total payments to be subtracted form total costs as described in (e)(1)(D)(ii);

(iii) Use the hospital's charge and payment data for claims for services described in (e)(1)(A) and (B) provided to Medicaid-enrolled and uninsured patients that were adjudicated during the program year; and

(iv) Include charges and payments for claims submitted after the 95-day filing deadline for Medicaid-allowable services provided during the program year unless such claims were submitted after the Medicare filing deadline.

(B) The final hospital-specific limit will be calculated at the time of the independent audit conducted under (i).

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

(g) DSH payment calculation.

(1) Establishment of DSH funding pools. From the amount of remaining DSH funds determined in (f)(2), HHSC will establish three DSH funding pools.

(A) Pool One.

(i) Pool One is equal to or less than $388,000,000; and

(ii) Pool One payments are available to all non-state-owned hospitals, including non-state-owned public hospitals.

(B) Pool Two.

(i) Pool Two is equal to or less than $600,000,000; and

(ii) Pool Two payments are available to all non-state-owned hospitals, including non-state-owned public hospitals.

(C) Pool Three.

(i) Pool Three is equal to or less than $420,000,000; and

(ii) Pool Three payments are available to Urban public hospitals – Class one and Class two and non-urban public hospitals.

(2) Weighting factors.

(A) HHSC will assign each non-urban public hospital a weighting factor of 1.21.

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

(B) HHSC will assign all other DSH hospitals not described in (g)(2)(A) a weighting factor of 1.00.

(3) Pass One distribution and payment calculation for Pools One and Two.

(A) HHSC will calculate each hospital's total DSH days as follows:

(i) Weighted Medicaid inpatient days are equal to the hospital's Medicaid inpatient days multiplied by the appropriate weighting factor from (g)(2).

(ii) Weighted low-income days are equal to the hospital's low-income days multiplied by the appropriate weighting factor from (g)(2).

(iii) Total DSH days equal the sum of weighted Medicaid inpatient days and weighted low-income days.

(B) Using the results from (g)(3)(A), HHSC will:

(i) Divide each hospital's total DSH days from (g)(3)(A)(iii) by the sum of total DSH days for all non-state-owned DSH hospitals to obtain a percentage.

(ii) Multiply each hospital's percentage as calculated in (g)(3)(B)(i) by the amount determined in (g)(1)(A) to determine each hospital's Pass One projected payment amount from Pool One.

(iii) Multiply each hospital's percentage as calculated in (g)(3)(B)(i) by the amount determined in (g)(1)(B) to determine each hospital's Pass One projected payment amount from Pool Two.

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

(iv) Sum each hospital's Pass One projected payment amount from Pool One and Pool Two, as calculated in (g)(3)(B)(ii) and (iii) respectively. The result of this calculation is the hospital's Pass One projected payment amount from Pools One and Two combined.

(v) Divide the Pass One projected payment amount from Pool Two as calculated in (g)(3)(B)(iii) by the hospital's Pass One projected payment amount from Pools One and Two combined as calculated in (g)(3)(B)(iv). The result of this calculation is the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two.

(4) Pass Two – Redistribution of amounts in excess of hospital-specific limits from Pass One for Pools One and Two combined. In the event that the projected payment amount calculated in (g)(3)(B)(iv) plus any previous payment amounts for the program year exceeds a hospital's interim hospital-specific limit, the payment amount will be reduced such that the sum of the payment amount plus any previous payment amounts is equal to the interim hospital-specific limit. HHSC will sum all resulting excess funds and redistribute that amount to qualifying non-state-owned hospitals that have projected payments, including any previous payment amounts for the program year, below their interim hospital-specific limits. For each such hospital, HHSC will:

(A) Subtract the hospital's projected DSH payment from (g)(3)(B)(iv) plus any previous payment amounts for the program year from its interim hospital-specific limit;

(B) Sum the results of (g)(4)(A) for all hospitals; and

(C) Compare the sum from (g)(4)(B) to the total excess funds calculated for all non-state-owned hospitals.

(i) If the sum of (g)(4)(B) is less than or equal to the total excess funds, HHSC will pay all such hospitals up to their interim hospital-specific limit.

(ii) If the sum of (g)(4)(B) is greater than the total excess funds, HHSC will calculate payments to all such hospitals as follows:

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

(I) Divide the result of (g)(4)(A) for each hospital by the sum from (g)(4)(B);

(II) Multiply the ratio from (g)(4)(C)(ii)(I) by the sum of the excess funds from all non-state-owned hospitals;

(III) Add the result of (g)(4)(C)(ii)(II) to the projected DSH payment for that hospital to calculate a revised projected payment amount from Pools One and Two after Pass Two.

(5) Pass One distribution and payment calculation for Pool Three.

(A) HHSC will calculate the initial payment from Pool Three as follows:

(i) For each Urban public hospital – Class one and Class two –

(I) Multiply its total Pool One and Pool Two payments after Pass Two from (g)(4) by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from (g)(3)(B)(v);

(II) Divide the result from (g)(5)(A)(i)(I) by the Federal Medical Assistance Percentage for the program year; and

(III) Multiply the result from (g)(5)(A)(i)(II) by the non-federal percentage. The result is the Pass One initial payment from Pool Three for these hospitals.

(ii) For each Non-urban public hospital –

(I) Multiply its total Pool One and Pool Two payments after Pass Two from (g)(4) by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from (g)(3)(B)(v);

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

(II) Divide the result from (g)(5)(A)(ii)(I) by the Federal Medical Assistance Percentage for the program year; and

(III) Multiply the result from (g)(5)(A)(ii)(II) by the non-federal percentage and multiply by 0.50. The result is the Pass One initial payment from Pool Three for these hospitals.

(iii) For all other hospitals, the Pass One initial payment from Pool Three is equal to zero.

(B) HHSC will calculate the secondary payment from Pool Three for each Urban public hospital – Class one as follows:

(i) Sum the interim hospital-specific limits for all Urban public hospitals – Class one;

(ii) For each Urban public hospital – Class one, divide its individual interim hospital-specific limit by the sum of the interim hospital-specific limits for all Urban public hospitals – Class one from (g)(5)(B)(i);

(iii) Sum all Pass One initial payments from Pool Three from (g)(5)(A);

(iv) Subtract the sum from (g)(5)(B)(iii) from the total value of Pool Three; and

(v) Multiply the result from (g)(5)(B)(ii) by the result from (g)(5)(B)(iv) for each Urban public hospital – Class One. The result is the Pass One secondary payment from Pool Three for that hospital.

(vi) For all other hospitals, the Pass One secondary payment from Pool Three is equal to zero.

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

(C) HHSC will calculate each hospital's total Pass One payment from Pool Three by adding its Pass One initial payment from Pool Three and its Pass One secondary payment from Pool Three.

(6) Pass Two – Secondary redistribution of amounts in excess of hospital-specific limits for Pool Three. For each hospital that received a Pass One initial or secondary payment from Pool Three, HHSC will sum the results from (g)(4) and (g)(5) to determine the hospital's total projected DSH payment. In the event this sum plus any previous payment amounts for the program year exceeds a hospital's interim hospital-specific limit, the payment amount will be reduced such that the sum of the payment amount plus any previous payment amounts is equal to the interim hospital-specific limit. HHSC will sum all resulting excess funds and redistribute that amount to qualifying non-state-owned hospitals eligible for payments from Pool Three that have projected payments, including any previous payment amounts for the program year, below their interim hospital-specific limits. For each such hospital, HHSC will:

(A) Subtract the hospital's projected DSH payment plus any previous payment amounts for the program year from its interim hospital-specific limit;

(B) Sum the results of (g)(6)(A) for all hospitals; and

(C) Compare the sum from (g)(6)(B) to the total excess funds calculated for all non-state-owned hospitals.

(i) If the sum of (g)(6)(B) is less than or equal to the total excess funds, HHSC will pay all such hospitals up to their interim hospital-specific limit.

(ii) If the sum of (g)(6)(B) is greater than the total excess funds, HHSC will calculate payments to all such hospitals as follows:

(I) Divide the result of (g)(6)(A) for each hospital by the sum from (g)(6)(B);

(II) Multiply the ratio from (g)(6)(C)(ii)(I) by the sum of the excess funds from all non-state-owned hospitals; and

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

(III) Add the result of (g)(6)(C)(ii)(II) to the projected total DSH payment for that hospital to calculate a revised projected payment amount from Pools One, Two and Three after Pass Two.

(7) Additional allocation of DSH funds for rural public and rural public-financed hospitals. Rural public hospitals or rural public-financed hospitals may be eligible for DSH funds in addition to the projected payment amounts calculated in (g)(3)-(6).

(A) For each rural public hospital or rural public-financed hospital, HHSC will determine the projected payment amount plus any previous payment amounts for the program year calculated in accordance with (g)(3)-(6);

(B) Subtract each hospital's projected payment amount plus any previous payment amounts for the program year from (g)(7)(A) from each hospital's interim hospital-specific limit to determine the maximum additional DSH allocation;

(C) Prior to processing any DSH payment that includes an additional allocation of DSH funds as described in (g)(7), HHSC will determine if such a payment would cause total DSH payments to exceed the available DSH funds for the payment as described in subsection (b)(2) of this section. If HHSC makes such a determination, it will reduce the DSH payment amounts rural public and rural public-financed hospitals are eligible to receive through the additional allocation as required to remain within the available DSH funds for the payment. This reduction will be applied proportionally to all additional allocations. HHSC will:

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**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

(i) determine remaining DSH funds by subtracting payment amounts for all DSH hospitals calculated in (g)(3)-(6) from the amount in (f)(2).

(ii) determine the total additional allocation for all hospitals eligible for an additional allocation.

(iii) determine an available proportion statistic by dividing the remaining DSH funds from (g)(7)(C)(i) by the total additional allocation from (g)(7)(C)(ii); and

(iv) multiply each eligible hospital's payment amount by the proportion statistic determined in (g)(7)(C)(iii). The resulting product will be the additional allowable allocation for the payment.

(8) Reallocating funds if a hospital closes, loses its license or eligibility. If a hospital that is receiving DSH funds closes, loses its license, or loses its Medicare or Medicaid eligibility during a DSH program year, HHSC will reallocate that hospital's disproportionate share funds going forward among all DSH hospitals in the same category that are eligible for additional payments.

(9) The sum of the annual payment amounts for state-owned and non-state-owned IMDs are summed and compared to the federal IMD limit. If the sum of the annual payment amounts exceeds the federal IMD limit, the state-owned and non-state owned IMDs are reduced on a pro-rata basis so that the sum is equal to the federal IMD limit.

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(10) Hospital located in a federal natural disaster area. If a hospital is located in a county that is declared a federal natural disaster area and that was participating in the DSH program at the time of the natural disaster, that hospital may request that HHSC determine its DSH qualification and interim reimbursement payment amount under this subsection for subsequent DSH program years. The final hospital specific limit will be computed based on the actual data for the DSH program year.

(11) HHSC will make DSH payments on a quarterly basis, unless factors outside of HHSC's control require a different payment schedule.

(12) DSH payments are final unless an overpayment is identified or a hospital becomes eligible for additional payments through the methodology described in (i)(3).

(13) No payment under this section is dependent on any agreement or arrangement that HHSC is aware of for providers or related entities to donate money or services to a governmental entity.

(h) Recovery of DSH funds. Notwithstanding any other provision of this section, HHSC will recoup any overpayment of DSH funds made to a hospital, including an overpayment that results from HHSC error or that is identified in an audit.

(i) Audit process.

(1) HHSC is required by the Social Security Act to annually complete an independent certified audit of each hospital participating in the DSH program in Texas.

(2) A hospital that fails to provide requested information or to otherwise comply with the independent certified audit requirements will be subject to a withholding of Medicaid disproportionate share payments or other appropriate sanctions.

(3) HHSC will recoup any overpayment of DSH funds made to a hospital that is identified in the independent certified audit and will redistribute the recouped funds to DSH providers that are eligible for additional payments subject to their final hospital-specific limits as described in (e)(2). Recouped funds will be redistributed as follows:

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

(A) HHSC will distribute recouped funds to hospitals that shared the same source of non-federal funds in the program year as the hospital from which the funds were recouped.

(B) The amount distributed to each hospital is the lesser of:

(i) A proportionate share of the recouped amount based on the hospital's percentage of total remaining final hospital-specific limits for all hospitals in that group; or

(ii) An amount equal to the hospital's remaining final hospital-specific limit.

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