TO: Medical Care Advisory Committee

DATE: June 13, 2019

FROM: Charles Greenberg, Director of Hospital Finance and Waiver Programs

SUBJECT: Disproportionate Share Hospital Program Unspent Funds and Hospital-Specific Limit Updates

Agenda Item No.:

Amendments to: §355.8065 Disproportionate Share Hospital Reimbursement Methodology, and §355.8066 Hospital-Specific Limit Methodology

BACKGROUND: ☒ Federal Requirement ☐ Legislative Requirement ☒ Other: Program Decision

The amendments will add language to the rules relating to methodology that the Texas Health and Human Services Commission (HHSC) will use to pay the unspent funds available for program years 2014 - 2017 Disproportionate Share Hospital (DSH), and for the calculation of the Hospital-Specific Limit (HSL) for these retrospective and prospective DSH payments.

The HSL is a limit on the amount of payments a hospital may receive for care to Medicaid and low income uninsured patients. HHSC calculates two types of HSLs: an interim HSL and a final HSL. The interim HSL is calculated to determine payment amounts using historical Medicaid and uninsured data. The final HSL is calculated later, during the audit of the program year, using the actual Medicaid and uninsured data from the relevant DSH data year to determine whether hospitals were overpaid. The interim HSL calculation determines the maximum payment amount using historical Medicaid and uninsured data reported. The final HSL calculation uses the actual data related to the program year. During a DSH audit of a program year, the final HSL is compared to the payment received. If the final HSL is lower than the payment amount, that amount is recouped by HHSC.

In 2010, the Centers for Medicare and Medicaid Services (CMS) promulgated a series of Frequently Asked Questions (FAQs) relating to the calculation of the final HSL. FAQ 33 stated that, when calculating the HSL, full payment from commercial insurers should offset the costs of Medicaid beneficiaries who also had commercial insurance.

In December 2014, Texas Children's Hospital sued CMS to stop enforcement of FAQ 33. The court issued a temporary injunction preventing CMS from enforcing that FAQ. In other words, CMS could not require a state to offset eligible DSH costs by payments from commercial insurers in the final HSL calculation.

Since the final HSL calculation described in Texas administrative rule and in the state plan is the same as the interim HSL calculation in all pertinent ways, the

injunction indirectly impacted the interim HSL calculation as well. Given the uncertainty of the outcome of this lawsuit, HHSC decided to leave 3.5% of DSH dollars unspent. That practice remained in effect for each DSH program year between 2014 and 2017.

In June 2017, CMS circulated a rule to codify FAQs 33 and 34, and the Children's Hospital Association of Texas sued CMS to prevent its enforcement. In March 2018, the federal district court vacated the rule, and in June 2018, CMS was permanently enjoined from enforcing FAQ 33. In December 2018, FAQs 33 and 34 were withdrawn.

As a result of this these developments, proposed amendments have been made to change the methodology for calculating the interim HSL used to distribute the unspent DSH funds. HHSC will reduce each hospital's revised interim HSL by the amount it has already received for the program year. HHSC will not recoup payments exceeding the interim HSL. HHSC will allocate the unspent DSH funds according to the reduced interim HSLs for all DSH hospitals. To allocate the unspent funds, HHSC will apply an "other insurance weight" and a "year-to-date payment weight" to increase Medicaid and low-income days in certain circumstances. Finally, if HHSC has calculated a final HSL for any program period (i.e., if the DSH audit has been performed), HHSC will cap the DSH payment for that program period at the final HSL amount.

Also, additional proposed amendments have been made to the methodology used for calculating the interim and final HSL for program periods beginning on or after October 1, 2017. The HSLs will be modified to exclude the offset of other insurance payments and Medicare payments to be consistent with the recent federal court decisions.

While revising the rule language to distribute the unspent funds and to exclude other insurance payments and Medicare payments from the HSL calculation, HHSC Rate Analysis Department (RAD) and Legal staff made some further minor updates. Staff clarified a few definitions, deleted unnecessary language, updated references to the Women's Health Program, and updated language requiring program-related communications be submitted via U.S. mail to be submitted by email instead.

ISSUES AND ALTERNATIVES:

Various hospital groups and stakeholders were solicited for their input when developing the retrospective methodology, including the Children's Hospital Association of Texas, Teaching Hospitals of Texas, the Texas Organization of Rural and Community Hospitals, and many individual stakeholders in the hospital community. Multiple scenarios for distributing the unspent DSH funds were modeled, and the methodology described in the proposed amendments appears to be satisfactory to these associations and providers.

STAKEHOLDER INVOLVEMENT:

HHSC conducted multiple meetings with stakeholders and provider representatives to gather input on the retrospective methodology to distribute the unspent DSH funds. The methodology appears to be satisfactory to key parties.

The crucial stakeholders in this decision process were the children's hospitals and the six large urban public hospitals. The children's hospitals had the largest impact to their payments from FAQ 33, and as such, the unspent funds are being distributed in a way that is consistent with the ruling in favor of children's hospitals.

Additionally, the entire non-federal share of the DSH payments for private hospitals is financed by the large urban public hospitals. The large urban public hospitals will not provide the non-federal share unless they, at a minimum, break-even. After negotiating with numerous stakeholders, the above changes to the methodologies were created.

HHSC Legal Services Department staff has reviewed the amended rules and determined that the rules meet all legal requirements for publication.

FISCAL IMPACT: Below is the additional revenue expected for state GR from state owned hospitals who participate in DSH based on these amendments.

☐ None ☒ Yes

	SFY 19	SFY 20	SFY 21	SFY 22	SFY 23
State	$22,388,340	$22,706,919	$23,222,843	$23,456,038	$21,988,761
Federal	$29,573,273	$29,999,363	$30,650,162	$30,886,724	$29,005,583
Total	$51,961,613	$52,706,282	$53,873,005	$54,342,762	$50,994,344

RULE DEVELOPMENT SCHEDULE:

April 2019	Publish proposed rules in *Texas Register*
May 2019	Present to the Hospital Payment Advisory Committee
June 2019	Present to the Medical Care Advisory Committee
June 2019	Present to HHSC Executive Council
June 2019	Publish adopted rules in *Texas Register*
July 2019	Effective date

REQUESTED ACTION:

☒ The HPAC can submit comments on the proposed rules.

☐ Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 4 MEDICAID HOSPITAL SERVICES

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology, and §355.8066, concerning Hospital-Specific Limit Methodology.

BACKGROUND AND PURPOSE

The purpose of the proposal is to describe the methodology for dispensing unspent Disproportionate Share Hospital (DSH) funds, to amend the methodology for calculating future DSH payments, to amend the calculation of the interim hospital-specific limit, and to update and clarify related rule language.

The hospital-specific limit (HSL) is a limit on the amount of payments a hospital may receive for care to Medicaid and low income uninsured patients. HHSC calculates two types of HSLs: an interim HSL and a final HSL. The interim HSL is calculated to determine payment amounts using historical Medicaid and uninsured data. The final HSL is calculated later, during the audit of the program year, using the actual Medicaid and uninsured data from the relevant DSH data year to determine whether hospitals were overpaid. The methodologies described in the state administrative rule and the state plan for calculating the interim and final HSLs are the same, except for a few minor differences.

In 2010, the Centers for Medicare and Medicaid Services (CMS) promulgated a series of Frequently Asked Questions (FAQs) relating to the calculation of the final HSL. FAQ 33 stated that, when calculating the HSL, full payment from commercial insurers should offset the costs of Medicaid beneficiaries who also had commercial insurance.

In December 2014, Texas Children's Hospital sued CMS to stop enforcement of FAQ 33. The court issued a temporary injunction preventing CMS from enforcing that FAQ. In other words, CMS could not require a state to offset eligible DSH costs by payments from commercial insurers in the final HSL calculation.

Since the final HSL calculation described in Texas administrative rule and in the state plan is the same as the interim HSL calculation in all pertinent ways, the injunction indirectly impacted the interim HSL calculation as well. Given the uncertainty of the outcome of this lawsuit, HHSC decided to leave 3.5% of DSH dollars unspent. That practice remained in effect for each DSH program year between 2014 and 2017.

In June 2017, CMS promulgated a rule that codified FAQ 33 and FAQ 34. (FAQ 34 required Medicare payments to offset the costs of Medicaid beneficiaries who were also eligible for Medicare). The Children's Hospital Association of Texas (CHAT) sued CMS to prevent enforcement of the rule. In March of 2018, the federal district court vacated the rule. Soon after, on June 1, 2018, the same federal court ruled in the *Texas Children's Hospital* case that CMS is permanently enjoined from enforcing FAQ 33. In December 2018, CMS withdrew FAQs 33 and 34 and communicated this decision in a published bulletin that also provided additional commentary on its expectations of implementing this change. Specifically, CMS noted that it would accept revised DSH audits that cover hospital services furnished before June 2, 2017, and that the costs reflected in these audits would not be offset by other insurance and Medicare payments.

Retrospective Methodology Changes for Dispensing Unspent Amounts

Some of the proposed amendments to §355.8066 change the methodology for calculating the interim HSL that HHSC will use to distribute the unspent DSH funds. The purpose of those amendments is to describe the interim HSL methodology that would have been used but for CMS' invalidated guidance in FAQ 33. HHSC will calculate an interim HSL by including all eligible costs for the program year and offsetting them by Medicaid and Medicare payments.

The proposed amendments to §355.8065 change the methodology for calculating the DSH payments for program years 2014 - 2017. The amendments are necessary because the current methodology does not account for HHSC's decision to not recoup from hospitals that have already received payments in excess of what they would receive with their revised HSLs.

First, HHSC will reduce each hospital's revised interim HSL by the amount it has already received for the program year. HHSC will then allocate the unspent DSH funds according to the reduced interim HSLs for all DSH hospitals.

To allocate the unspent funds, HHSC will apply an "other insurance weight" and a "year-to-date payment weight" to increase Medicaid and low-income days in certain circumstances.

The other insurance weight is calculated by dividing the unrevised HSL by the amount of third party commercial insurance payments from the DSH data year for each hospital. The result, if greater than one, is used as a weight to increase the Medicaid and low-income days for the provider. The purpose of applying the other insurance weight is to address the circumstances of providers that had large amounts of other insurance offset against their HSL and consequently received significantly smaller DSH payments.

The year-to-date payment weight addresses the circumstances of providers that had large amounts of other insurance offset against their HSL. In program years 2014 - 2017, certain providers were not eligible to receive a DSH payment because

of the large amount of other insurance payments offsetting their costs in the HSL calculation. The unspent amounts are the only source of DSH payment for these providers for the relevant program years. Because HHSC is not recouping payments in excess of revised interim HSLs given the threat to the safety net in doing so, the providers who have not received any year-to-date payments are even further limited to what they can receive. Therefore, a weight of 20 is proposed to increase the Medicaid and low-income days for those providers.

Finally, if HHSC has calculated a final HSL for any program period (i.e., if the DSH audit has been performed), HHSC will cap the DSH payment for that program period at the final HSL amount.

Prospective Methodology Changes

The proposed rule amendments to §355.8066 change the methodology for calculating the interim and final HSL for program periods beginning on or after October 1, 2017, by providing that the HSL will not be offset by other insurance payments or Medicare payments. However, HHSC continues to evaluate alternate methods of prospectively calculating the interim HSL. HHSC is particularly interested in receiving comments regarding these amendments to §355.8066.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.8065(b) clarifies the definition of “interim hospital-specific limit” by deleting the term “during” and adding the word “for;” clarifies the definitions of “total Medicaid inpatient days” by adding the phrase “or HHSC;” clarifies the definition of “total Medicaid inpatient hospital payments” by adding the phrase “and HHSC;” and removes obsolete language from the definition of “urban public hospital - class two.”

The proposed amendment to §355.8065(f) adds language to describe the methodology for calculating disbursements of the unspent funds, specifically the process to ensure that a provider is not paid an amount in excess of the interim HSL amount.

The proposed amendment to §355.8065(h) adds language to describe the weighting factors used in calculating disbursements of the unspent funds. The amendment also adds language to describe the methodology for calculating disbursements of the unspent funds, specifically the process to ensure that a provider is not paid an amount in excess of the final HSL amount.

The proposed amendment to §355.8066(b) updates the definition of “hospital-specific limit” and “the waiver” by deleting unnecessary language; clarifies the definition of “interim hospital-specific limit” by deleting the term “during” and adding the word “for;” and deletes the definition of “Medicaid allowable cost” to align with the deletion of §355.8066(c)(1)(B)(i)(III).

The proposed amendment to §355.8066(c) updates a reference to the Women's Health Program; deletes §355.8066(c)(1)(B)(i)(III), which is obsolete; amends the calculation of the interim HSL; and amends §355.8066(c)(2)(A), the final HSL, which cross-references to the revised interim HSL calculation.

The proposed amendment to §355.8066(d) updates the rule language related to acceptance of a request for an extension to submit a DSH or non-DSH survey by deleting references to hand delivery, U.S. mail or special mail delivery and adding a requirement that the request be submitted by email.

The proposed amendment to §355.8066(e) updates the rule language related to a hospital's request for review of DSH or non-DSH survey data by adding a requirement that the request be submitted by email and amending language related to the recipient of the request.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years that the rules will be in effect, there will be an estimated increase in revenue to state and local government as a result of enforcing and administering the rules as proposed.

The net effect on state government for each year of the first five years the proposed rules are in effect is an estimated revenue increase of $29,573,273 General Revenue (GR) ($51,961,613 All Funds (AF)) in State Fiscal Year (SFY) 2019, $29,999,363 GR in ($52,706,282 AF) SFY 2020, $30,650,162 GR ($53,873,005 AF) in SFY 2021, $30,886,724 GR ($54,342,762 AF) in SFY 2022, and $29,005,583 GR ($50,994,344 AF) in SFY 2023.

The proposed rule will also allow small public hospitals to receive additional DSH payments for prior periods (SFY 2014 - 2017) in the amount of $10,374,658, providing additional revenue to local government entities affiliated with these hospitals.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

(1) the proposed rules will not create or eliminate a government program;

(2) implementation of the proposed rules will not affect the number of HHSC employee positions;

(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;

(4) the proposed rules will not affect fees paid to HHSC;

(5) the proposed rules will not create a new rule;

(6) the proposed rules will not expand, limit, or repeal existing rules;

(7) the proposed rules will not change the number of individuals subject to the rules; and

(8) the proposed rules will positively affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Greta Rymal, Deputy Executive Commissioner for Financial Services, has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The proposed rules do not impose any additional costs on any small businesses, micro-businesses, or rural communities required to comply.

LOCAL EMPLOYMENT IMPACT

There is a possibility of a negative impact on local employment in some communities and a positive impact in others. The change in DSH reimbursement methodology will impact distribution of DSH funds to participating hospitals. Certain providers may receive greater reimbursement while others may receive less than they would under the current rules.

HHSC lacks sufficient data to both predict communities in which there may be an employment impact and to determine the potential impacts on local employment in those communities.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to receive a source of federal funds or comply with federal law; and these rules do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Rate Analysis, has determined that for each year of the first five years the rules are in effect, the public benefit will be ensuring that HHSC is able to distribute the full amount of DSH payments available.

Greta Rymal, Deputy Executive Commissioner for Financial Services, has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC HEARING

HHSC will receive public comments on the proposal during the Hospital Payment Advisory Committee (HPAC) meeting on May 6, 2019, at 1:30 pm in the Brown-Heatly Public Hearing Room. The meeting will be webcast and can be viewed on the HHSC website at: https://texashhsc.swagit.com/live.

Persons requiring further information, special assistance, or accommodations should contact Camille Weizenbaum at 512-487-3446.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Mance Fine at (512) 462-6386 in HHSC Hospital Rate Analysis.

Written comments on the proposal may be submitted to HHSC, c/o Mance Fine, Mail Code H400, 4900 North Lamar Blvd, Austin, Texas 78751-2316, or by email to uctools@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or e-mailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When faxing or e-mailing comments, please indicate "Comments on Proposed Rules 19R035" in the subject line.

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the Health and Human Services agencies, Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance (Medicaid) payments under Texas Human Resources Code Chapter 32.

The amendments affect Texas Government Code §531.0055, Texas Government Code Chapter 531, and Texas Human Resources Code Chapter 32.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 462-6386.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language
(No change.) = No changes are being considered for the designated subdivision

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 4 MEDICAID HOSPITAL SERVICES

§355.8065. Disproportionate Share Hospital 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. The Texas Health and Human Services Commission (HHSC) will establish each hospital's eligibility for and amount of reimbursement using the methodology described in this section.

(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 total amount of funds that may be distributed to eligible qualifying DSH hospitals for the DSH program year, based on the federal DSH allotment for Texas (as determined by the Centers for Medicare & Medicaid Services) and available non-federal funds. HHSC may divide available DSH funds for a program year into one or more portions of funds to allow for partial payment(s) of total available DSH funds at any one time with remaining funds to be distributed at a later date(s). If HHSC chooses to make a partial payment, the available DSH funds for that partial payment are limited to the portion of funds identified by HHSC for that partial payment.

(3) Available general revenue funds--The total amount of state general revenue funds appropriated to provide a portion of the non-federal share of DSH payments for the DSH program year for non-state-owned hospitals. If HHSC divides available DSH funds for a program year into one or more portions of funds to allow for partial payment(s) of total available DSH funds as described in paragraph (2) of this subsection, the available general revenue funds for that partial payment are limited to the portion of general revenue funds identified by HHSC for that partial payment.

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

(5) 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, or its successor.

(6) 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. A hospital must set the income level for eligibility for charity care consistent with the criteria established in §311.031, Texas Health and Safety Code.

(7) 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.

(8) Children's hospital--A hospital within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(9) Disproportionate share hospital (DSH)--A hospital identified by HHSC that meets the DSH program conditions of participation and that serves a disproportionate share of Medicaid or indigent patients.

(10) DSH data year--A twelve-month period, two years before the DSH program year, from which HHSC will compile data to determine DSH program qualification and payment.

(11) DSH program year--The twelve-month period beginning October 1 and ending September 30.

(12) Dually eligible patient--A patient who is simultaneously eligible for Medicare and Medicaid.

(13) Governmental entity--A state agency or a political subdivision of the state. A governmental entity includes a hospital authority, hospital district, city, county, or state entity.

(14) HHSC--The Texas Health and Human Services Commission or its designee.

(15) Hospital-specific limit--The maximum amount applicable to a DSH program year that a hospital may receive in reimbursement for the cost of providing services to individuals who are Medicaid eligible or uninsured. The hospital-specific limit is calculated using the methodology described in §355.8066 of this title (relating to Hospital-Specific Limit Methodology).

(A) Interim hospital-specific limit--Applies to payments that will be made for [~~during~~] the DSH program year and is calculated using the methodology described

in §355.8066 of this title using interim cost and payment data from the DSH data year.

(B) Final hospital-specific limit--Applies to payments made during a prior DSH program year and is calculated using the methodology as described in §355.8066 of this title using actual cost and payment data from the DSH program year.

(16) Independent certified audit--An audit that is conducted by an auditor that operates independently from the Medicaid agency and the audited hospitals and that is eligible to perform the DSH audit required by CMS.

(17) Indigent individual--An individual classified by a hospital as eligible for charity care.

(18) Inpatient day--Each day that an individual is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The term includes observation days, rehabilitation days, psychiatric days, and newborn days. The term does not include swing bed days or skilled nursing facility days.

(19) Inpatient revenue--Amount of gross inpatient revenue derived from the most recent completed Medicaid cost report or reports related to the applicable DSH data year. Gross inpatient revenue excludes revenue related to the professional services of hospital-based physicians, swing bed facilities, skilled nursing facilities, intermediate care facilities, other nonhospital revenue, and revenue not identified by the hospital.

(20) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.

(21) Intergovernmental transfer (IGT)--A transfer of public funds from a governmental entity to HHSC.

(22) Low-income days--Number of inpatient days attributed to indigent patients, calculated as described in subsection (h)(4)(A)(ii) of this section.

(23) Low-income utilization rate--A ratio, calculated as described in subsection (d)(2) of this section, that represents the 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 report--Hospital and Hospital Health Care Complex Cost Report (Form CMS 2552), also known as the Medicare cost report.

(27) Medicaid hospital--A hospital meeting the qualifications set forth in §354.1077 of this title (relating to Provider Participation Requirements) to participate in the Texas Medicaid program.

(28) Medicaid inpatient utilization rate (MIUR)--A ratio, calculated as described in subsection (d)(1) of this section, that represents a hospital's volume of Medicaid inpatient services relative to total inpatient services.

(29) 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."

(30) Non-federal percentage--The non-federal percentage equals one minus the federal medical assistance percentage (FMAP) for the program year.

(31) Non-urban public hospital--A rural public-financed hospital, as defined in paragraph (37) of this subsection, or a hospital owned and operated by a governmental entity other than hospitals in Urban public hospital - Class one or Urban public hospital - Class two.

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

(34) 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.

(35) 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.

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

(37) Rural public-financed hospital--A 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, where the hospital and governmental entity have both signed an attestation that they wish the hospital to be treated as a public hospital for all purposes under both this section and §355.8201 of this title (relating to Waiver Payments to Hospitals for Uncompensated Care).

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

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

(40) 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.

(41) 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 or HHSC;

(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 MIUR calculation described in subsection (d)(1) of this section.

(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 following calculations:

(I) Total Medicaid inpatient days, as described in subsection (d)(3) of this section; and

(II) Pass one distribution, as described in subsection (h)(4) of this section.

(42) 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 hospital received:

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

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

(43) Total state and local payments--Total amount of state and local payments that a hospital received for inpatient 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, such as County Indigent Health Care, Children with Special Health Care Needs, and Kidney Health Care. The term excludes payment sources that contain federal dollars such as Medicaid payments, Children's Health Insurance Program (CHIP) payments funded under Title XXI of the Social Security Act, Substance Abuse and Mental Health Services Administration, Ryan White Title I, Ryan White Title II, Ryan White Title III, and contractual discounts and allowances related to TRICARE, Medicare, and Medicaid.

(44) Urban public hospital--Any of the urban hospitals listed in paragraph (45) or (46) of this subsection.

(45) Urban public hospital - Class one--A hospital that is operated by or under a lease contract with one of the following 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 dba Central Health, or the University Health System of Bexar County.

(46) Urban public hospital - Class two--A hospital that is operated by or under a lease contract with one of the following entities: the Ector County Hospital District, the Lubbock County Hospital District, or [~~, beginning in DSH program year 2016,~~] the Nueces County Hospital District.

(c) Eligibility. To be eligible to participate in the DSH program, a hospital must:

(1) be enrolled as a Medicaid hospital in the State of Texas;

(2) 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; and

(3) apply annually by completing the application packet received from HHSC by the deadline specified in the packet.

(A) Only a hospital that meets the condition specified in paragraph (2) of this subsection will receive an application packet from HHSC.

(B) The application may request self-reported data that HHSC deems necessary to determine each hospital's eligibility. HHSC may audit self-reported data.

(C) A hospital that fails to submit a completed application by the deadline specified by HHSC will not be eligible to participate in the DSH program in the year being applied for or to appeal HHSC's decision.

(D) For purposes of DSH eligibility, a multi-site hospital is considered one provider unless it submits separate Medicaid cost reports for each site. If a multi-site hospital submits separate Medicaid cost reports for each site, for purposes of DSH eligibility, it must submit a separate DSH application for each site.

(E) HHSC will consider a merger of two or more hospitals for purposes of the DSH program for any hospital that submits documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application. Otherwise, HHSC will determine the merged entity's eligibility for the subsequent DSH program year. Until the time that the merged hospitals are determined eligible for payments as a merged hospital, each of the merging hospitals will continue to receive any DSH payments to which it was entitled prior to the merger.

(d) Qualification. For each DSH program year, in addition to meeting the eligibility requirements, 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 Medicaid 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 clauses (i) and (ii) of this subparagraph:

(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).

(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 this paragraph.

(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 under this subsection will be deemed to qualify. A hospital deemed to qualify must still meet the eligibility requirements under subsection (c) of this section and the conditions of participation under subsection (e) of this section.

(5) Merged hospitals. Merged hospitals are subject to the application requirement in subsection (c)(3)(E) of this section. 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 hospital(s). In these instances, HHSC will apportion the Medicaid DSH funding determination for the data year hospital between the data year hospital and the new program year hospital(s) based on estimates of the division of Medicaid inpatient and low income utilization between the data year hospital and the new program year hospital(s) for the program year, so long as all affected providers satisfy the Medicaid DSH conditions of participation under subsection (e) of this section and qualify as separate hospitals under subsection (d) of this section based on HHSC's Medicaid DSH qualification criteria in the applicable Medicaid DSH program year. In determining whether the new program year hospital(s) meet the Medicaid DSH conditions of participation and qualification, proxy program year data may be used.

(e) Conditions of participation. HHSC will require each hospital to meet and continue to meet for each DSH program year the following conditions of participation:

(1) Two-physician requirement.

(A) In accordance with Social Security Act §1923(e)(2), a hospital must have at least two licensed physicians (doctor of medicine or osteopathy) who have hospital staff privileges and who have agreed to provide nonemergency obstetrical services to individuals who are entitled to medical assistance for such services.

(B) Subparagraph (A) of this paragraph does not apply if the hospital:

(i) serves inpatients who are predominantly under 18 years of age; or

(ii) was operating but did not offer nonemergency obstetrical services as of December 22, 1987.

(C) A hospital must certify on the DSH application that it meets the conditions of either subparagraph (A) or (B) of this paragraph, as applicable, at the time the DSH application is submitted.

(2) Medicaid inpatient utilization rate. At the time of qualification and during the DSH program year, a hospital must have a Medicaid inpatient utilization rate, as calculated in subsection (d)(1) of this section, of at least one percent.

(3) Trauma system.

(A) The hospital must be in active pursuit of designation or have obtained a

trauma facility designation as defined in §780.004 and §§773.111 - 773.120, Texas Health and Safety Code, respectively, and consistent with 25 TAC §157.125 (relating to Requirements for Trauma Facility Designation) and §157.131 (relating to the Designated Trauma Facility and Emergency Medical Services Account). 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 subsection (o) of this section.

(7) Merged hospitals. Merged hospitals are subject to the application requirement in subsection (c)(3)(E) of this section. 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 continue receiving DSH payments for the remainder of the DSH program year.

(8) Changes that may affect DSH participation. A hospital receiving payments under this section must notify HHSC's Rate Analysis Department within 30 days of changes in ownership, operation, provider identifier, designation as a trauma facility or as a children's hospital, or any other change that may affect the hospital's continued eligibility, qualification, or compliance with DSH conditions of participation. At the request of HHSC, the hospital must submit any documentation supporting the change.

(f) Hospital-specific limit calculation. HHSC uses the methodology described in §355.8066 of this title to calculate an interim hospital-specific limit for each Medicaid hospital that applies and qualifies to receive payments during the DSH

program year under this section, and a final hospital-specific limit for each hospital that received payments in a prior program year under this section. For payments for each DSH program year beginning before October 1, 2017, the interim hospital-specific limit calculated as described in §355.8066 will be reduced by the amount of prior payments received by each participating hospital for that DSH program year. These prior payments will not be considered anywhere else in the calculation.

(g) Distribution of available DSH funds. HHSC will distribute the available DSH funds as defined in subsection (b)(2) of this section among eligible, qualifying DSH hospitals using the following priorities:

(1) State-owned teaching hospitals, state-owned IMDs, and state chest hospitals. HHSC may reimburse state-owned teaching hospitals, state-owned IMDs, and state chest hospitals an amount less than or equal to their interim hospital-specific limits, except that aggregate payments to IMDs statewide may not exceed federally mandated reimbursement limits for IMDs.

(2) Other hospitals. HHSC distributes the remaining available DSH funds, if any, to other qualifying hospitals using the methodology described in subsection (h) of this section.

(A) The remaining available DSH funds equal the lesser of the funds as defined in subsection (b)(2) of this section less funds expended under paragraph (1) of this subsection or the sum of remaining qualifying hospitals' interim hospital-specific limits.

(B) The remaining available general revenue funds equal the funds as defined in subsection (b)(3) of this section.

(h) DSH payment calculation.

(1) Data verification. HHSC uses the methodology described in §355.8066(e) of this title to verify the data used for the DSH payment calculations described in this subsection. The verification process includes:

(A) notice to hospitals of the data provided to HHSC by Medicaid contractors; and

(B) an opportunity for hospitals to request HHSC review of disputed data.

(2) Establishment of DSH funding pools. From the amount of remaining DSH funds determined in subsection (g)(2) of this section, HHSC will establish three DSH funding pools.

(A) Pool One.

(i) Pool One is equal to the sum of the remaining available general

revenue funds and associated federal matching funds; 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 the lesser of:

(I) the amount of remaining DSH funds determined in subsection (g)(2) of this section less the amount determined in paragraph (2)(A) of this subsection multiplied by the FMAP in effect for the program year; or

(II) the federal matching funds associated with the intergovernmental transfers received by HHSC that make up the funds for Pool Three; and

(ii) Pool Two payments are available to all non-state-owned hospitals except for any urban public hospital as defined in subsection (b)(44) of this section; rural public hospital as defined in subsection (b)(36) of this section; or rural public-financed hospital as defined in subsection (b)(37) of this section owned by or affiliated with a governmental entity that does not transfer any funds to HHSC for Pool Three as described in subparagraph (C)(iii) of this paragraph.

(C) Pool Three.

(i) Pool Three is equal to the sum of intergovernmental transfers for DSH payments received by HHSC from governmental entities that operate or are under lease contracts with Urban public hospitals - Class one and Class two and non-urban public hospitals.

(ii) Pool Three payments are available to the hospitals that are operated by or under lease contracts with the governmental entities described in clause (i) of this subparagraph that provide intergovernmental transfers.

(iii) HHSC will allocate responsibility for funding Pool Three as follows:

(I) Urban public hospitals - Class two. Each governmental entity that operates or is under a lease contract with an Urban public hospital - Class two is responsible for funding an amount equal to the non-federal share of Pass One and Pass Two DSH payments from Pool Two (calculated as described in paragraphs (4) and (5) of this subsection) to that hospital.

(II) Non-urban public hospitals.

(-a-) Each governmental entity that operates or is under a lease contract with a non-urban public hospital is responsible for funding one-half of the non-federal share of the hospital's Pass One and Pass Two DSH payments from Pool

Two (calculated as described in paragraphs (4) and (5) of this subsection) to that hospital.

(-b-) If general revenue available for Pool One does not equal at least one-half of the non-federal share of non-urban public hospitals' Pass One and Pass Two DSH payments from Pool Two, each governmental entity that operates or is under a lease contract with a non-urban public hospital is responsible for increasing its funding of the non-federal share of that hospital's Pass One and Pass Two DSH payments from Pool Two by an amount equal to the Pool One general revenue shortfall associated with the hospital.

(III) Urban public hospitals - Class one. Each governmental entity that operates or is under a lease contract with an Urban public hospital - Class one is responsible for funding the non-federal share of the Pass One and Pass Two DSH payments from Pool Two (calculated as described in paragraphs (4) and (5) of this subsection) to its affiliated hospital and a portion of the non-federal share of the Pass One and Pass Two DSH payments from Pool Two to private hospitals. For funding payments to private hospitals, HHSC will initially suggest an amount in proportion to each Urban public hospital - Class one's individual interim hospital-specific limit relative to total hospital-specific limits for all Urban public hospitals - Class one. If an entity transfers less than the suggested amount, HHSC will take the steps described in paragraph (5)(F) of this subsection.

(IV) Following the calculations described in paragraphs (4) and (5) of this subsection, HHSC will notify each governmental entity of its allocated intergovernmental transfer amount.

(3) Weighting factors.

(A) HHSC will assign each non-urban public hospital a weighting factor that is calculated as follows:

(i) Determine the non-federal percentage in effect for the program year and multiply by 0.50.

(ii) Add 1.00 to the result from clause (i) of this subparagraph and round the result to two decimal places; this rounded sum is the non-urban public hospital weighting factor.

(iii) If paragraph (2)(C)(iii)(II)(-b-) of this subsection is invoked, the 0.50 referenced in clause (i) of this subparagraph will be increased to represent the increased proportion of the non-federal share of non-urban public hospitals' Pass One and Pass Two DSH payments from Pool Two required to be funded by these hospitals' associated governmental entities.

(B) All other DSH hospitals not described in subparagraph (A) of this paragraph will be assigned a weighting factor of 1.00, except for DSH program years beginning before October 1, 2017, HHSC will assign weighting factors as

follows to each non-state DSH hospital: [-]

(i) Other Insurance Weight. HHSC will divide the interim hospital-specific limit calculated according to §355.8066 (c)(1)(D)(ii)(I)(-a-), except that costs are reduced by payments from all payors, by the amount of third party commercial insurance payments for that hospital from the DSH data year.

(I) The result, if greater than 1, will be used as a weighting factor.

(II) If the result is less than 1, no weighting factor will be applied.

(ii) Year-To-Date Payment Weight. HHSC will assign a weighting factor of 20 to any hospital that did not receive any prior payments for that DSH program year. This weighting factor will be added to the weighting factor calculated in clause (i) of this subparagraph.

(4) 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 factors [~~factor~~] from paragraph (3) of this subsection.

(ii) Low-income days are equal to the hospital's low-income utilization rate as calculated in subsection (d)(2) of this section multiplied by the hospital's total inpatient days as defined in subsection (b)(18) of this section.

(iii) Weighted low-income days are equal to the hospital's low-income days multiplied by the appropriate weighting factors [~~factor~~] from paragraph (3) of this subsection.

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

(B) Using the results from subparagraph (A) of this paragraph, HHSC will:

(i) Divide each hospital's total DSH days from subparagraph (A)(iv) of this paragraph 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 clause (i) of this subparagraph by the amount determined in paragraph (2)(A) of this subsection to determine each hospital's Pass One projected payment amount from Pool One.

(iii) Multiply each hospital's percentage as calculated in clause (i) of this subparagraph by the amount determined in paragraph (2)(B)(i)(I) or (II) of this

subsection, as appropriate, to determine each hospital's Pass One projected payment amount from Pool Two.

(iv) Sum each hospital's Pass One projected payment amounts from Pool One and Pool Two, as calculated in clauses (ii) and (iii) of this subparagraph 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 clause (iii) of this subparagraph by the hospital's Pass One projected payment amount from Pools One and Two combined as calculated in clause (iv) of this subparagraph. The result of this calculation is the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two.

(5) 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 paragraph (4)(B)(iv) of this subsection 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 paragraph (4)(B)(iv) of this subsection plus any previous payment amounts for the program year from its interim hospital-specific limit;

(B) sum the results of subparagraph (A) of this paragraph for all hospitals; and

(C) compare the sum from subparagraph (B) of this paragraph to the total excess funds calculated for all non-state-owned hospitals.

(i) If the sum of subparagraph (B) of this paragraph 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 subparagraph (B) of this paragraph is greater than the total excess funds, HHSC will calculate payments to all such hospitals as follows:

(I) Divide the result of subparagraph (A) of this paragraph for each hospital by the sum from subparagraph (B) of this paragraph.

(II) Multiply the ratio from subclause (I) of this clause by the sum of the excess funds from all non-state-owned hospitals.

(III) Add the result of subclause (II) of this clause to the projected DSH payment for that hospital to calculate a revised projected payment amount from Pools One and Two after Pass Two.

(D) If a governmental entity that operates or leases to an Urban public hospital - Class two does not fully fund the amount described in paragraph (2)(C)(iii)(I) of this subsection, HHSC will reduce the hospital's Pass One and Pass Two DSH payment from Pool Two to the level supported by the amount of the intergovernmental transfer.

(E) If a governmental entity that operates or is under a lease contract with a non-urban public hospital does not fully fund the amount described in paragraph (2)(C)(iii)(II) of this subsection, HHSC will reduce that portion of the hospital's Pass One and Pass Two DSH payment from Pool Two to the level supported by the amount of the intergovernmental transfer.

(F) If a governmental entity that operates or leases to an Urban public hospital - Class one does not fully fund the amount described in paragraph (2)(C)(iii)(III) of this subsection, HHSC will take the following steps:

(i) Provide an opportunity for the governmental entities affiliated with the other Urban public hospitals - Class one to transfer additional funds to HHSC;

(ii) Recalculate total DSH days for each Urban public hospital - Class one for purposes of the calculations described in paragraphs (4)(B) and (5)(A) - (C) of this subsection as follows:

(I) Divide the intergovernmental transfer made on behalf of each Urban public hospital - Class one by the sum of intergovernmental transfers made on behalf of all Urban public hospitals - Class one;

(II) Sum the total DSH days for all Urban public hospitals - Class one, calculated as described in paragraph (4)(A) of this subsection; and

(III) Multiply the result of subclause (I) of this clause by the result of subclause (II) of this clause to determine total DSH days for that hospital;

(iii) Recalculate Pass One payments from Pool Two and Pass Two payments from Pools One and Two for Urban public hospitals - Class one and private hospitals following the methodology described in paragraphs (4)(B) and (5)(A) - (C) of this subsection substituting the results from clause (ii) of this subparagraph for the results from paragraph (4)(A) of this subsection for Urban public hospitals - Class one;

(iv) Perform a second recalculation of Pass Two payments from Pools One and Two for Urban public hospitals - Class one as follows:

(I) Multiply each hospital's total Pass Two projected payment amount from Pools One and Two from paragraph (5) of this subsection, after performing the recalculation described in clause (iii) of this subparagraph, by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from paragraph (4)(B)(v) of this subsection, after performing the recalculation described in clause (iii) of this subparagraph. The result is the hospital's Pass Two projected payment amount from Pool Two;

(II) Subtract the hospital's Pass Two projected payment amount from Pool Two from subclause (I) of this clause from the hospital's total Pass Two projected payment amount from Pools One and Two from paragraph (5) of this subsection, after performing the recalculation described in clause (iii) of this subparagraph. The result is the hospital's Pass Two projected payment amount from Pool One;

(III) Sum the total Pass Two projected payment amounts from Pool Two, calculated as described in subclause (I) of this clause, for all Urban public hospitals - Class one;

(IV) Multiply the result of clause (ii)(I) of this subparagraph for the hospital by the result of subclause (III) of this clause to determine the Pass Two payment from Pool Two for the hospital; and

(V) Sum the results of subclauses (II) and (IV) of this clause to determine the total Pass Two payment from Pools One and Two for that hospital; and

(v) Use the results of this subparagraph in the calculations described in paragraphs (6) and (7) of this subsection.

(6) 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 paragraph (5) of this subsection by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from paragraph (4)(B)(v) of this subsection;

(II) divide the result from subclause (I) of this clause by the FMAP for the program year; and

(III) multiply the result from subclause (II) of this clause 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 paragraph (5) of this subsection by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from paragraph (4)(B)(v) of this subsection;

(II) divide the result from subclause (I) of this clause by the FMAP for the program year; and

(III) multiply the result from subclause (II) of this clause by the non-federal percentage and multiply by 0.50. The result is the Pass One initial payment from Pool Three for these hospitals.

(IV) If paragraph (2)(C)(iii)(II)(-b-) of this subsection is invoked, the 0.50 referenced in subclause (III) of this clause will be increased to represent the increased proportion of the non-federal share of non-urban public hospitals' Pass One and Pass Two DSH payments from Pool Two required to be funded by these hospitals' associated governmental entities.

(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 intergovernmental transfers made on behalf of all Urban public hospitals - Class one;

(ii) For each Urban public hospital - Class one, divide the intergovernmental transfer made on behalf of that hospital by the sum of the intergovernmental transfers made on behalf of all Urban public hospitals - Class one from clause (i) of this subparagraph;

(iii) Sum all Pass One initial payments from Pool Three from subparagraph (A) of this paragraph;

(iv) Subtract the sum from clause (iii) of this subparagraph from the total value of Pool Three; and

(v) Multiply the result from clause (ii) of this subparagraph by the result from clause (iv) of this subparagraph 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.

(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.

(7) 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 result from paragraph (5) of this subsection and the result from paragraph (6) of this subsection 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 subparagraph (A) of this paragraph for all hospitals; and

(C) compare the sum from subparagraph (B) of this paragraph to the total excess funds calculated for all non-state-owned hospitals.

(i) If the sum of subparagraph (B) of this paragraph 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 subparagraph (B) of this paragraph is greater than the total excess funds, HHSC will calculate payments to all such hospitals as follows:

(I) Divide the result of subparagraph (A) of this paragraph for each hospital by the sum from subparagraph (B) of this paragraph.

(II) Multiply the ratio from subclause (I) of this clause by the sum of the excess funds from all non-state-owned hospitals.

(III) Add the result of subclause (II) of this clause 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.

(8) Pass Three - additional allocation of DSH funds for rural public and rural public-financed hospitals. Rural public hospitals or rural public-financed hospitals that met the funding requirements described in paragraph (2)(C) of this subsection

may be eligible for DSH funds in addition to the projected payment amounts calculated in paragraphs (4) - (7) of this subsection.

(A) For each rural public hospital or rural public financed hospital that met the funding requirements described in paragraph (2)(C) of this subsection, HHSC will determine the projected payment amount plus any previous payment amounts for the program year calculated in accordance with paragraphs (4) - (7) of this subsection, as appropriate.

(B) HHSC will subtract each hospital's projected payment amount plus any previous payment amounts for the program year from subparagraph (A) of this paragraph from each hospital's interim hospital-specific limit to determine the maximum additional DSH allocation.

(C) The governmental entity that owns the hospital or leases the hospital may provide the non-federal share of funding through an intergovernmental transfer to fund up to the maximum additional DSH allocation calculated in subparagraph (B) of this paragraph. These governmental entities will be queried by HHSC as to the amount of funding they intend to provide through an intergovernmental transfer for this additional allocation. The query may be conducted through e-mail, through the various hospital associations or through postings on the HHSC website.

(D) Prior to processing any full or partial DSH payment that includes an additional allocation of DSH funds as described in this paragraph, HHSC will determine if such a payment would cause total DSH payments for the full or partial payment 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:

(i) determine remaining available funds by subtracting payment amounts for all DSH hospitals calculated in paragraphs (4) - (7) of this subsection from the amount in subsection (g)(2) of this section;

(ii) determine the total additional allocation supported by an intergovernmental transfer by summing the amounts supported by intergovernmental transfers identified in subparagraph (C) of this paragraph;

(iii) determine an available proportion statistic by dividing the remaining available funds from clause (i) of this subparagraph by the total additional allocation supported by an intergovernmental transfer from clause (ii) of this subparagraph; and

(iv) multiply each intergovernmental transfer supported payment from subparagraph (C) of this paragraph by the proportion statistic determined in clause

(iii) of this subparagraph. The resulting product will be the additional allowable allocation for the payment.

(E) Rural public and rural public-financed hospitals that do not meet the funding requirements of paragraph (2)(C)(iii)(II) of this subsection are not eligible for participation on Pass Three.

(9) Reallocating funds if hospital closes, loses its license or eligibility, or files bankruptcy. If a hospital closes, loses its license, loses its Medicare or Medicaid eligibility, or files bankruptcy before receiving DSH payments for all or a portion of a DSH program year, HHSC will determine the hospital's eligibility to receive DSH payments going forward on a case-by-case basis. In making the determination, HHSC will consider multiple factors including whether the hospital was in compliance with all requirements during the program year and whether it can meet the audit requirements described in subsection (o) of this section. If HHSC determines that the hospital is not eligible to receive DSH payments going forward, HHSC will notify the hospital and reallocate that hospital's disproportionate share funds going forward among all DSH hospitals in the same category that are eligible for additional payments.

(10) HHSC will give notice of the amounts determined in this subsection.

(11) 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.

(12) For any DSH program year for which HHSC has calculated the final hospital-specific limit described in §355.8066(c)(2) of this chapter, HHSC will compare the interim DSH payment amount as calculated in subsection (h) of this section to the final hospital-specific limit.

A) HHSC will limit the payment amount to the final hospital-specific limit if the payment amount exceeds their final hospital-specific limit.

(B) HHSC will redistribute dollars made available as a result of the capping described in (A) to providers eligible for additional payments subject to their final hospital-specific limits, as described in subsection (l) of this section.

(i) Hospital located in a federal natural disaster area. A hospital that 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 may request that HHSC determine its DSH qualification and interim reimbursement payment amount under this subsection for subsequent DSH program years. The following conditions and procedures will apply to all such requests received by HHSC:

(1) The hospital must submit its request in writing to HHSC with its annual DSH

application.

(2) If HHSC approves the request, HHSC will determine the hospital's DSH qualification using the hospital's data from the DSH data year prior to the natural disaster. However, HHSC will calculate the one percent Medicaid minimum utilization rate, the interim hospital-specific limit, and the payment amount using data from the DSH data year. The final hospital-specific limit will be computed based on the actual data for the DSH program year.

(3) HHSC will notify the hospital of the qualification and interim reimbursement.

(j) HHSC determination of eligibility or qualification. HHSC uses the methodology described in §355.8066(e) of this title to verify the data and other information used to determine eligibility and qualification under this section. The verification process includes:

(1) notice to hospitals of the data provided to HHSC by Medicaid contractors; and

(2) an opportunity for hospitals to request HHSC review of disputed data and other information the hospital believes is erroneous.

(k) Disproportionate share funds held in reserve.

(1) If HHSC has reason to believe that a hospital is not in compliance with the conditions of participation listed in subsection (e) of this section, HHSC will notify the hospital of possible noncompliance. Upon receipt of such notice, the hospital will have 30 calendar days to demonstrate compliance.

(2) If the hospital demonstrates compliance within 30 calendar days, HHSC will not hold the hospital's DSH payments in reserve.

(3) If the hospital fails to demonstrate compliance within 30 calendar days, HHSC will notify the hospital that HHSC is holding the hospital's DSH payments in reserve. HHSC will release the funds corresponding to any period for which a hospital subsequently demonstrates that it was in compliance. HHSC will not make DSH payments for any period in which the hospital is out of compliance with the conditions of participation listed in subsection (e)(1) and (2) of this section. HHSC may choose not to make DSH payments for any period in which the hospital is out of compliance with the conditions of participation listed in subsection (e)(3) - (7) of this section.

(4) If a hospital's DSH payments are being held in reserve on the date of the last payment in the DSH program year, and no request for review is pending under paragraph (5) of this subsection, the amount of the payments is not restored to the hospital, but is divided proportionately among the hospitals receiving a last payment.

(5) Hospitals that have DSH payments held in reserve may request a review by HHSC.

(A) The hospital's written request for a review must:

(i) be sent to HHSC's Director of Hospital Rate Analysis, Rate Analysis Department;

(ii) be received by HHSC within 15 calendar days after notification that the hospital's DSH payments are held in reserve; and

(iii) contain specific documentation supporting its contention that it is in compliance with the conditions of participation.

(B) The review is:

(i) limited to allegations of noncompliance with conditions of participation;

(ii) limited to a review of documentation submitted by the hospital or used by HHSC in making its original determination; and

(iii) not conducted as an adversarial hearing.

(C) HHSC will conduct the review and notify the hospital requesting the review of the results.

(l) 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. Recovered funds will be redistributed proportionately to DSH hospitals that had the same source of the non-federal share of the DSH payment in the program year in which the overpayment occurred and that are eligible for additional payments for that program year. For example, funds recovered from state-owned hospitals will be redistributed first to other state-owned hospitals that are eligible for additional payments for that program year. If there are no hospitals eligible for additional payments for that program year that had the same source of the non-federal share of the recovered funds, any remaining funds will be distributed as follows:

(1) the non-federal share will be returned to the governmental entity that provided it during the program year;

(2) the federal share will be distributed proportionately among all hospitals eligible for additional payments that have a source of the non-federal share of the payments; and

(3) the federal share that does not have a source of non-federal share will be returned to CMS.

(m) Failure to provide supporting documentation. HHSC will exclude data from DSH calculations under this section if a hospital fails to maintain and provide adequate documentation to support that data.

(n) Voluntary withdrawal from the DSH program.

(1) HHSC will recoup all DSH payments made during the same DSH program year to a hospital that voluntarily terminates its participation in the DSH program. HHSC will redistribute the recouped funds according to the distribution methodology described in subsection (l) of this section.

(2) A hospital that voluntarily terminates from the DSH program will be ineligible to receive payments for the next DSH program year after the hospital's termination.

(3) If a hospital does not apply for DSH funding in the DSH program year following a DSH program year in which it received DSH funding, even though it would have qualified for DSH funding in that year, the hospital will be ineligible to receive payments for the next DSH program year after the year in which it did not apply.

(4) The hospital may reapply to receive DSH payments in the second DSH program year after the year in which it did not apply.

(o) Audit process.

(1) Independent certified audit. HHSC is required by the Social Security Act (Act) to annually complete an independent certified audit of each hospital participating in the DSH program in Texas. Audits will comply with all applicable federal law and directives, including the Act, the Omnibus Budget and Reconciliation Act of 1993 (OBRA '93), the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), pertinent federal rules, and any amendments to such provisions.

(A) Each audit report will contain the verifications set forth in 42 CFR §455.304(d).

(B) The sources of data utilized by HHSC, the hospitals, and the independent auditors to complete the DSH audit and report include:

(i) The Medicaid cost report;

(ii) Medicaid Management Information System data; and

(iii) Hospital financial statements and other auditable hospital accounting records.

(C) A hospital must provide HHSC or the independent auditor with the necessary information in the time specified by HHSC or the independent auditor. HHSC or the independent auditor will notify hospitals of the required information and provide a reasonable time for each hospital to comply.

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

(E) 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 subsection (l) of this section.

(F) Review of preliminary audit finding of overpayment.

(i) Before finalizing the audit, HHSC will notify each hospital that has a preliminary audit finding of overpayment.

(ii) A hospital that disputes the finding or the amount of the overpayment may request a review in accordance with the following procedures.

(I) A request for review must be received by the HHSC Rate Analysis Department in writing by regular mail, hand delivery or special mail delivery, from the hospital within 30 calendar days of the date the hospital receives the notification described in clause (i) of this subparagraph.

(II) The request must allege the specific factual or calculation errors the hospital contends the auditors made that, if corrected, would change the preliminary audit finding.

(III) All documentation supporting the request for review must accompany the written request for review or the request will be denied.

(IV) The request for review may not dispute the federal audit requirements or the audit methodologies.

(iii) The review is:

(I) limited to the hospital's allegations of factual or calculation errors;

(II) solely a data review based on documentation submitted by the hospital with its request for review or that was used by the auditors in making the preliminary finding; and

(III) not an adversarial hearing.

(iv) HHSC will submit to the auditors all requests for review that meet the procedural requirements described in clause (ii) of this subparagraph.

(I) If the auditors agree that a factual or calculation error occurred and change the preliminary audit finding, HHSC will notify the hospital of the revised finding.

(II) If the auditors do not agree that a factual or calculation error occurred and do not change the preliminary audit finding, HHSC will notify the hospital that the preliminary finding stands and will initiate recoupment proceedings as described in this section.

(2) Additional audits. HHSC may conduct or require additional audits.

§355.8066. Hospital-Specific Limit Methodology.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to calculate a hospital-specific limit for each Medicaid hospital participating in either the Disproportionate Share Hospital (DSH) program, described in §355.8065 of this title (relating to Disproportionate Share Hospital Reimbursement Methodology), or in the Texas Healthcare Transformation and Quality Improvement Program (the waiver), described in §355.8201 of this title (relating to Waiver Payments to Hospitals).

(b) Definitions.

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

(2) Centers for Medicare and Medicaid Services (CMS)--The federal agency within the United States Department of Health and Human Services responsible for overseeing and directing Medicare and Medicaid, or its successor.

(3) Data year--A 12-month period that is two years before the program year from which HHSC will compile data to determine DSH or uncompensated-care waiver program qualification and payment.

(4) Disproportionate share hospital (DSH)--A hospital identified by HHSC that meets the DSH program conditions of participation and that serves a disproportionate share of Medicaid or indigent patients.

(5) DSH survey--The HHSC data collection tool completed by each DSH hospital and used by HHSC to calculate the interim and final hospital-specific limit, as described in this section, and to estimate the hospital's DSH payments for the program year, as described in §355.8065 of this title. A hospital may be required to complete multiple surveys due to different data requirements between the interim and final hospital-specific limit calculations.

(6) Dually eligible patient--A patient who is simultaneously enrolled in Medicare and Medicaid.

(7) HHSC--The Texas Health and Human Services Commission or its designee.

(8) Hospital-specific limit--The maximum payment amount that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid eligible or uninsured. The term does not apply to payment for costs of providing services to non-Medicaid-eligible individuals who have third-party coverage; costs associated with pharmacies, clinics, and physicians; or costs associated with Delivery System Reform Incentive Payment projects. The calculation of the hospital-specific limit must be consistent with federal law [~~as determined by the Secretary of the United States Department of Health and Human Services and CMS~~].

(A) Interim hospital-specific limit--Applies to payments that will be made for [~~during~~] the program year and is calculated as described in subsection (c)(1) of this section using cost and payment data from the data year.

(B) Final hospital-specific limit--Applies to payments made during a prior program year and is calculated as described in subsection (c)(2) of this section using actual cost and payment data from that period.

(9) Inflation update factor--Cost of living index based on the annual CMS Prospective Payment System Hospital Market Basket Index.

(10) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness, defined in §1905(i) of the Social Security Act.

[~~(11) Medicaid allowable cost--The allowable charge for a claim multiplied by the applicable ratio of cost-to-charges from subsection (b)(19) of this section for the cost reporting period described in subsection (c)(1)(C)(i) of this section. This term is only used in subsection (c)(1)(B)(i)(III) of this section.~~]

(11) [~~(12)~~] Medicaid contractor--Fiscal agents and managed care organizations with which HHSC contracts to process data related to the Medicaid program.

(12) [~~(13)~~] 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 payor types such as Medicare, Medicaid, or private pay.

(13) [(~~14~~)] Medicaid cost report--Hospital and Hospital Health Care Complex Cost Report (Form CMS 2552), also known as the Medicare cost report.

(14) [~~(15)~~] Medicaid hospital--A hospital meeting the qualifications set forth in §54.1077 of this title (relating to Provider Participation Requirements) to participate in the Texas Medicaid program.

(15) [~~(16)~~] Non-DSH survey--The HHSC data collection tool completed by non-DSH hospitals and used by HHSC to calculate the interim and final hospital-specific limit, as described in this section, and to calculate uncompensated care waiver payments for the program year, as described in §355.8201 of this title. A hospital may be required to complete multiple surveys due to different data requirements between the interim and final hospital-specific limit calculations.

(16) [~~(17)~~] Outpatient charges--Amount of gross outpatient charges related to the applicable data year and used in the calculation of the hospital specific limit.

(17) [~~(18)~~] Program year--The 12-month period beginning October 1 and ending September 30. The period corresponds to the waiver demonstration year.

(18) [~~(19)~~] Ratio of cost-to-charges.

(A) Inpatient ratio of cost-to-charges--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.

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

(C) The terms "ratio of cost-to-charges"; "inpatient ratio of cost-to-charges"; and "outpatient ratio of cost-to-charges" are only used in the definition of "Medicaid allowable cost" as laid out in subsection (b)(11) of this section.

(19) [~~(20)~~] 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~~]. Pertinent to this section, the waiver establishes a funding pool to assist hospitals with uncompensated-care costs.

(20) [~~(21)~~] 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 payor.

(21) [~~(22)~~] Total state and local payments--Total amount of state and local payments that a hospital received for inpatient care during the 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, such as County Indigent Health Care, Children with Special Health Care Needs, and Kidney Health Care. The term excludes payment sources that contain federal dollars such as Medicaid

payments, Children's Health Insurance Program (CHIP) payments funded under Title XXI of the Social Security Act, Substance Abuse and Mental Health Services Administration, Ryan White Title I, Ryan White Title II, Ryan White Title III, and contractual discounts and allowances related to TRICARE, Medicare, and Medicaid.

(22) [~~(23)~~] 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.

(23) [~~(24)~~] Uninsured cost--The cost to a hospital of providing inpatient and outpatient hospital services to uninsured patients as defined by CMS.

(c) Calculating a hospital-specific limit. Using information from each hospital's DSH or non-DSH survey, Medicaid cost report and from HHSC's Medicaid contractors, HHSC will determine the hospital's interim hospital-specific limit in compliance with paragraph (1) of this subsection. The interim hospital-specific limit will be used for both DSH and uncompensated care waiver interim payment determinations. Final hospital-specific limits will be determined in compliance with paragraph (2) of this subsection.

(1) Interim Hospital-Specific Limit.

(A) Uninsured charges and payments.

(i) Each hospital will report in its survey its inpatient and outpatient charges for services that would be covered by Medicaid that were provided to uninsured patients discharged during the data year. In addition to the charges in the previous sentence, for DSH calculation purposes only, an IMD may report charges for Medicaid-allowable services that were provided during the data year to Medicaid-eligible and uninsured patients ages 21 through 64.

(ii) Each hospital will report in its survey all payments received during the data year, regardless of when the service was provided, for services that would be covered by Medicaid and were provided to uninsured patients.

(I) For purposes of this paragraph, a payment received is any payment from an uninsured patient or from a third party (other than an insurer) on the patient's behalf, including payments received for emergency health services furnished to undocumented aliens under §1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, except as described in subclause (II) of this clause.

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

(B) 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 data year.

(I) The requested data will include, but is not limited to, charges and payments for:

(-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;

(-c-) outpatient claims associated with the Women's Health Program; and

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

(II) HHSC will exclude charges and payments for:

(-a-) claims for services that do not meet the definition of "medical assistance" contained in §1905(a) of the Social Security Act. Examples include:

(-1-) claims for the Children's Health Insurance Program; and

(-2-) inpatient claims associated with the Women's Health Program or any successor program; and

(-b-) claims submitted after the 95-day filing deadline.

[~~(III) Contingent upon the approval of a corresponding Medicaid State Plan amendment by CMS that contains the specific policies prescribed by this subclause, to the extent that third-party commercial payment exceeds the Medicaid allowable cost for a service provided to a recipient and for which reimbursement was not paid under the medical assistance program, the payment is not considered a medical assistance payment. If such an amendment is not approved by CMS, the payment is considered a medical assistance payment and HHSC will include the entire payment amount in the calculation described in subparagraph (D)(ii)(I) of this paragraph.~~]

(ii) HHSC will request from its Medicaid contractors the inpatient and outpatient Medicaid cost settlement payment or recoupment amounts attributable to the cost report period determined in subparagraph (C)(i) of this paragraph.

(iii) HHSC will notify hospitals following HHSC's receipt of the requested data from the Medicaid contractors. A hospital's right to request a review of data it

believes is incorrect or incomplete is addressed in subsection (e) of this section.

(iv) Each hospital will report on the survey the inpatient and outpatient Medicaid days, charges and payment data for out-of-state claims adjudicated during the data year.

(v) HHSC may apply an adjustment factor to Medicaid payment data to more accurately approximate Medicaid payments following a rebasing or other change in reimbursement rates under other sections of this division.

(C) Calculation of in-state and out-of-state Medicaid and uninsured total costs for the data year.

(i) Cost report period for data used to calculate cost-per-day amounts and cost-to-charge ratios. HHSC will use information from the Medicaid cost report for the hospital's fiscal year that ends during the calendar year that falls two years before the end of the program year for the calculations described in clauses (ii)(I) and (iii)(I) of this subparagraph. For example, for program year 2013, the cost report year is the provider's fiscal year that ends between January 1, 2011, and December 31, 2011.

(I) For hospitals that do not have a full year cost report that meets this criteria, a partial year cost report for the hospital's fiscal year that ends during the calendar year that falls two years before the end of the program year will be used if the cost report covers a period greater than or equal to six months in length.

(II) The partial year cost report will not be prorated. If the provider's cost report that ends during this time period is less than six months in length, the most recent full year cost report will be used.

(ii) Determining inpatient routine costs.

(I) Medicaid inpatient cost per day for routine cost centers. Using data from the Medicaid cost report, HHSC will divide the allowable inpatient costs by the inpatient days for each routine cost center to determine a Medicaid inpatient cost per day for each routine cost center.

(II) Inpatient routine cost center cost. For each Medicaid payor type and the uninsured, HHSC will multiply the Medicaid inpatient cost per day for each routine cost center from subclause (I) of this clause times the number of inpatient days for each routine cost center from the data year to determine the inpatient routine cost for each cost center.

(III) Total inpatient routine cost. For each Medicaid payor type and the uninsured, HHSC will sum the inpatient routine costs for the various routine cost centers from subclause (II) of this clause to determine the total inpatient routine

cost.

(iii) Determining inpatient and outpatient ancillary costs.

(I) Inpatient and outpatient Medicaid cost-to-charge ratio for ancillary cost centers. Using data from the Medicaid cost report, HHSC will divide the allowable ancillary cost by the sum of the inpatient and outpatient charges for each ancillary cost center to determine a Medicaid cost-to-charge ratio for each ancillary cost center.

(II) Inpatient and outpatient ancillary cost center cost. For each Medicaid payor type and the uninsured, HHSC will multiply the cost-to-charge ratio for each ancillary cost center from subclause (I) of this clause by the ancillary charges for inpatient claims and the ancillary charges for outpatient claims from the data year to determine the inpatient and outpatient ancillary cost for each cost center.

(III) Total inpatient and outpatient ancillary cost. For each Medicaid payor type and the uninsured, HHSC will sum the ancillary inpatient and outpatient costs for the various ancillary cost centers from subclause (II) of this clause to determine the total ancillary cost.

(iv) Determining total Medicaid and uninsured cost. For each Medicaid payor type and the uninsured, HHSC will sum the result of clause (ii)(III) of this subparagraph and the result of clause (iii)(III) of this subparagraph plus organ acquisition costs to determine the total cost.

(D) Calculation of the interim hospital-specific limit.

(i) Total hospital cost. HHSC will sum the total cost by Medicaid payor type and the uninsured from subparagraph (C)(iv) of this paragraph to determine the total hospital cost for Medicaid and the uninsured.

(ii) Interim hospital-specific limit.

(I) HHSC will reduce the total hospital cost under clause (i) of this subparagraph by total payments as follows:

(-a-) For program periods beginning on or after October 1, 2017, payments [~~from all payor sources~~] for inpatient and outpatient claims, under Title XIX of the Social Security Act, including graduate medical services and out-of-state payments, and payments on behalf of the uninsured; and [~~except as limited by subparagraph (B)(i)(III) of this paragraph, and including but not limited to, graduate medical services and out-of-state payments.~~]

(-b-) For program periods beginning on or after October 1, 2013 and ending on or before September 30, 2017, from all payor sources, including

graduate medical services and out-of-state payments, excluding third-party commercial insurance payors for inpatient and outpatient claims.

(II) HHSC will not reduce the total hospital cost under clause (i) of this subparagraph by supplemental payments (including upper payment limit payments), or uncompensated-care waiver payments for the data year to determine the interim hospital-specific limit. HHSC may reduce the total hospital cost by supplemental payments or uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributed to the hospital for the program year if necessary to prevent total interim payments to a hospital for the program year from exceeding the interim hospital-specific limit for that program year.

(E) Inflation adjustment.

(i) HHSC will trend each hospital's interim hospital-specific limit using the inflation update factor.

(ii) HHSC will trend each hospital's-specific limit from the midpoint of the data year to the midpoint of the program year.

(2) 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 paragraph (1)(A) - (D)(ii)(I)(-a-) of this subsection, 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 paragraphs (1)(C)(ii)(I) and (1)(C)(iii)(I) of this subsection. 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 from total costs as described in paragraph (1)(D)(ii)(I)(-a-) of this subsection;

(iii) use the hospital's actual charges and payments for services described in paragraph (1)(A) and (B) of this subsection provided to Medicaid-eligible and uninsured patients 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) For payments to a hospital under the DSH program, the final hospital-specific limit will be calculated at the time of the independent audit conducted under §355.8065(o) of this title.

(d) Due date for DSH or non-DSH survey.

(1) HHSC Rate Analysis must receive a hospital's completed survey no later than 30 calendar days from the date of HHSC's written request to the hospital for the completion of the survey, unless an extension is granted as described in paragraph (2) of this subsection.

(2) HHSC Rate Analysis will extend this deadline provided that HHSC receives a written request for the extension by email [~~hand delivery, U.S. mail, or special mail delivery~~] no later than 30 calendar days from the date of the request for the completion of the survey.

(3) The extension gives the requester a total of 45 calendar days from the date of the written request for completion of the survey.

(4) If a deadline described in paragraph (1) or (3) of this subsection is a weekend day, national holiday, or state holiday, then the deadline for submission of the completed survey is the next business day.

(5) HHSC will not accept a survey or request for an extension that is not received by the stated deadline. A hospital whose survey or request for extension is not received by the stated deadline will be ineligible for DSH or uncompensated-care waiver payments for that program year.

(e) Verification and right to request a review of data. This subsection applies to calculations under this section beginning with calculations for program year 2014.

(1) Claim adjudication. Medicaid participating hospitals are responsible for resolving disputes regarding adjudication of Medicaid claims directly with the appropriate Medicaid contractors as claims are adjudicated. The review of data described under paragraph (2) of this subsection is not the appropriate venue for resolving disputes regarding adjudication of claims.

(2) Request for review of data.

(A) HHSC will pre-populate certain fields in the DSH or non-DSH survey, including data from its Medicaid contractors.

(i) A hospital may request that HHSC review any data in the hospital's DSH or non-DSH survey that is pre-populated by HHSC.

(ii) A hospital may not request that HHSC review self-reported data included in the DSH or non-DSH survey by the hospital.

(B) A hospital must submit via email a written request for review and all supporting documentation to HHSC [~~HHSC's Director of~~] Hospital Rate Analysis within 30 days following the distribution of the pre-populated DSH or non-DSH survey to the hospital by HHSC. The request must allege the specific data omissions or errors that, if corrected, would result in a more accurate HSL.

(3) HHSC's review.

(A) HHSC will review the data that is the subject of a hospital's request. The review is:

(i) limited to the hospital's allegations that data is incomplete or incorrect;

(ii) supported by documentation submitted by the hospital or by the Medicaid contractor;

(iii) solely a data review; and

(iv) not an adversarial hearing.

(B) HHSC will notify the hospital of the results of the review.

(i) If changes to the Medicaid data are made as a result of the review process, HHSC will use the corrected data for the HSL calculations described in this section and for other purposes described in §355.8065 and §355.8201 of this title.

(ii) If no changes are made, HHSC will use the Medicaid data from the Medicaid contractors.

(C) HHSC will not consider requests for review submitted after the deadline specified in paragraph (2)(B) of this subsection.

(D) HHSC will not consider requests for review of the following calculations that rely on the Medicaid data and other information described in this subsection:

(i) the hospital-specific limit calculated as described in this section;

(ii) DSH program qualification or payment amounts calculated as described in §355.8065 of this title;

(iii) uncompensated-care payment amounts calculated as described in §355.8201 of this title.