Table of Contents

State/Territory Name: Texas

State Plan Amendment (SPA) #: TX 23-0046

This file contains the following documents in the order listed:

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

Financial Management Group

July 18, 2024

Emily Zalkovsky
State Medicaid/CHIP Director
Health and Human Services Commission
Mail Code: H100
Post Office Box 13247
Austin, Texas 78711

RE: TN 23-0046

Dear Emily Zalkovsky:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Texas state plan amendment (SPA) to Attachment 4.19-A TX 23-0046, which was submitted to CMS on December 28, 2023. This plan amendment updates the Disproportionate Share Hospital (DSH) program reimbursement methodology and revises the DSH allotment distributed among eligible hospitals.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), and 1923 of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of October 1, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Tom Caughey via email at tom.caughey@cms.hhs.gov or Diana Dinh via email at diana.dinh@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0046

2. STATE: TX

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
§ 1923 of the Social Security Act; 42 CFR §§ 447.294-299

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
SEE ATTACHMENTS TO BLOCKS 7-8

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
SEE ATTACHMENTS TO BLOCKS 7-8

9. SUBJECT OF AMENDMENT

The proposed amendment updates the Disproportionate Share Hospital (DSH) program reimbursement methodology. The proposed amendment also revises the way that the State's DSH allotment is distributed among eligible hospitals.

10. GOVERNOR'S REVIEW *(Check One)*

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Valerie Mayes

13. TITLE
Deputy State Medicaid Director
(Signing on behalf of Emily Zalkovsky, State Medicaid Director)

14. DATE SUBMITTED
December 28, 2023

15. RETURN TO
Emily Zalkovsky
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR CMS USE ONLY

16. DATE RECEIVED
December 28, 2023

17. DATE APPROVED
July 18, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
FMG, Director

22. REMARKS

FORM CMS-179 (09/24)

Disproportionate Share Hospital (DSH) Reimbursement Methodology

(a) Introduction. Hospitals participating in the Texas Medicaid program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for reimbursement from the disproportionate share hospital (DSH) fund. HHSC will establish each hospital's eligibility for and amount of reimbursement using the methodology described in this appendix beginning with the DSH program year corresponding with federal fiscal year 2024. For program periods that correspond with federal fiscal year 2023, eligibility and payments will be made in accordance with the rule text in Texas Administrative Code §355.8065 and §355.8066 as it existed on June 1, 2023.

(b) Definitions.

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

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

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

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

(5) Charity care - The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to indigent individuals, either directly or through other nonprofit or public outpatient clinics, hospitals, or health care organizations. A hospital must set the income level for eligibility for charity care consistent with the criteria established in Medicare and §311.031, Texas Health and Safety Code.

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

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

(7) 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.

(8) 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.

(9) 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.

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

(11) Dually eligible patient – A patient who is simultaneously eligible for Medicare and Medicaid.

(12) Federal medical assistance percentage (FMAP)— A percentage used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures. Section 1905(b) of the Social Security Act specifies the formula for calculating Federal Medical Assistance Percentages

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

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

(15) Hospital-specific limit - The maximum payment amount, as applied to payments made during a prior DSH program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid eligible or uninsured. The hospital-specific limit is the maximum payment amount authorized by Section 1923(g) of the Social Security Act that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured for payments made during a prior program year. The amount is calculated using actual cost and payment data from that period. The term does not apply to payment for costs of providing services to non-Medicaid-eligible individuals who have third-party coverage; and costs associated with pharmacies, clinics, and physicians.

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

(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) Inflation update factor – Cost-of-living index based on the annual CMS prospective payment system hospital market basket index.

(19) Inpatient day – Each day that an individual is 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.

(20) 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.

(21) 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.

(22) Institution for mental diseases (IMD) cap - An IMD limit determined each fiscal year and as described under Section 1923(h) of the Social Security Act.

(23) Intergovernmental Transfer (IGT) – a transfer of public funds from a governmental entity to HHSC.

(24) Low-income days - Number of inpatient days attributed to indigent patients are calculated using the following methodology. Low-income days are equal to the hospitals low-income utilization rate as calculated in subsection (d)(2) of this section multiplied by the hospitals total inpatient days.

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

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

(26) 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.

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

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

(29) Medicaid cost report - Hospital and Hospital Health Care Complex Cost Report (Form CMS 2552), also known as the Medicare cost report.

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

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

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

(32) 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."

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

(34) Non-rural hospital - Any hospital that does not meet the definition of rural hospital as defined in this state plan.

(35) Non-urban public hospital - A hospital other than a transferring public hospital that is:

(A) owned and operated by a governmental entity; or

(B) operated under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county, and 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 the Uncompensated Charity Care program.

(36) 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.

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

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

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

(40) 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.

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

(41) Public Health Hospital (PHH) - The Texas Center for Infectious Disease or any successor facility operated by the Department of State Health Services.

(42) 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.

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

(44) State Institution for mental diseases (State 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 and that is owned and operated by a state university or other state agency.

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

(45) State-owned hospital - A hospital that is defined as a state IMD, state-owned teaching hospital, or a Public Health Hospital (PHH) in the state plan.

(46) State-owned teaching hospital - Acute care hospitals owned and operated by the state of Texas.

(47) State payment cap - The maximum payment amount, as applied to payments that will be made for the DSH program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured.

(48) 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.

(49) 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.

(50) 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 calculation in (d)(1).

(B) The term excludes:
(vi) days attributable to Medicaid-eligible patients ages 21 through 64 in an IMD;
(vii) days denied for late filing and other reasons; and
(viii) days for dually eligible patients for purposes of the calculation in (d)(3) and (h)(4).

(51) 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.

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

The term includes payments that the hospital received:

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

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

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

(53) 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.

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

(55) Transferring public hospital - A hospital that is owned and operated by 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, or the University Health System of Bexar County.

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

(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 multisite 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) Merged Hospitals.

(i) HHSC will consider a merger of two or more hospitals for purposes of determining eligibility and calculating a hospital's DSH program year payments under this section if:

I. a hospital that was a party to the merger submits to HHSC documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application; and

II. the hospital submitting the information under subclause (I) assumed all Medicaid-related liabilities of each hospital that is a party to the merger, as determined by HHSC after review of the applicable agreements.

(ii) If the requirements of clause (i) are not met, HHSC will not consider the merger for purposes of determining eligibility or calculating a hospital's DSH program year payments under this section. Until HHSC determines that the hospitals are 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.

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

(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 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. For purposes of paragraph (2) of this section, the term "low-income utilization rate" is calculated using the calculation described in 42 U.S.C. §1396r–4 (b)(3).

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

(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 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.

(B) Days for dually eligible patients are not included in the calculation of total Medicaid inpatient days under this paragraph.

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

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

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

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 and qualify as separate hospitals 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) The requirement in (e)(1)(A) does not apply if the hospital:

(i) Serves inpatients who are predominately 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 (e)(1)(A) or (B), 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 (d)(1), of at least one percent.

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

(3) Trauma system.

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

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

(C) The following hospital types are exempted from the condition of participation described in this paragraph: Children's Hospitals, IMDs, Public Health Hospitals, and State IMDs.

(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 (o).

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

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

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 Provider Finance 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.

(9) Participation in all voluntary Medicaid programs. Beginning in Federal Fiscal Year (FFY) 2024, it will be required for all non-rural hospitals, except for state-owned hospitals, to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs, within the State of Texas to participate in DSH, unless:

(A) a hospital is not required to enroll, participate in, and comply with the requirements of a program without multiple components if the hospital's estimated payment from the entire program is less than $25,000; or of a program's component for programs that have multiple components if the hospital's estimated payment from the program's component is less than $25,000; and

(B) enrollment for the program concluded after the effective date of this requirement.

(f) State payment cap and hospital-specific limit calculation. Using information from each hospital's DSH survey, Medicaid cost report and from HHSC's Medicaid contractors, HHSC will determine the interim hospital-specific limit for each hospital applying for DSH funds in compliance with (f)(1)(A) - (E). HHSC will also determine the final hospital-specific limit in compliance with (f)(2).

(1) Calculation of uninsured and Medicaid costs and payments.

(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 DSH data year. In addition to the charges in the previous sentence, an IMD may report charges for Medicaid allowable services that were provided during the DSH 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.

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

(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 section §1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, except as described in (f)(1)(A)(ii)(II);

(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 DSH 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.

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

(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 from the Children's Health Insurance

Program; and

(-2-) Inpatient claims associated with the Women's Health Program; and

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

(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 (f)(1)(C)(i).

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

(iv) 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.

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

(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 (f)(1)(C)(ii)(I) and (iii)(I). 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 (f)(1)(C)(ii)(I) 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.

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

(III) Total inpatient routine cost. For each Medicaid payer type and the uninsured, HHSC will sum the inpatient routine costs for the various routine cost centers from (f)(1)(C)(ii)(II) 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. For each Medicaid payor type and the uninsured, HHSC will multiply the cost-to-charge ratio for each ancillary cost center from (f)(1)(C)(iii)(l)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 (f)(1)(C)(iii)(ll)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 (f)(1)(C)(ii)(lll)and the result of (f)(1)(C)(iii)(III) plus organ acquisition costs to determine the total cost.

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

(2) Calculation of the full-offset payment ceiling

(A) Total hospital cost. HHSC will sum the total cost by Medicaid payor type and the uninsured from (f)(1)(C)(iv) to determine the total hospital cost for Medicaid and the uninsured.

(B) Total hospital payments. HHSC will reduce the total hospital cost under subparagraph A of this paragraph by total payments from all payor sources, including but not limited to, graduate medical services and out-of-state payments. HHSC shall 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 to prevent total interim payments to a hospital for the program year from exceeding the interim hospital-specific limit for that program year.

(C) Inflation adjustment. HHSC will trend each hospital's full-offset payment ceiling using the inflation update factor. HHSC will trend each hospital's state payment cap from the midpoint of the data year to the midpoint of the program year.

(3) Calculation of the Recoupment Prevention Payment Ceiling.

(A) Total hospital cost. HHSC will calculate total cost in accordance with Section 1923(g) of the Social Security Act. For example, starting with the program period beginning October 1, 2022, HHSC will sum the total cost from paragraph (1)(C)(iv) for the Medicaid primary payor type and the uninsured only.

(B) Total hospital cost. HHSC will calculate total cost in accordance with Section 1923(g) of the Social Security Act. For example, starting with the program period beginning October 1, 2022, HHSC will sum the total cost from paragraph (1)(C)(iv) for the Medicaid primary payor type and the uninsured only.

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

(C) Total hospital payments. HHSC will reduce the total hospital cost under subparagraph (A) of this paragraph by total payments in accordance with Section 1923(g) of the Social Security Act. For example, starting with the program period beginning October 1, 2022, HHSC will reduce the total hospital cost under subparagraph (A) of this paragraph by the total payments from Medicaid and the uninsured, including graduate medical services and out-of-state payments. HHSC shall 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 to prevent total interim payments to a hospital for the program year from exceeding the state payment cap for that program year.

(D) Inflation adjustment. HHSC will trend each hospital's recoupment prevention payment ceiling using the inflation update factor. HHSC will trend each hospital's state payment cap from the midpoint of the data year to the midpoint of the program year.

(E) A hospital that believes that it qualifies for an exception authorized by Section 1923(g) of the Social Security Act to the calculation described in this paragraph may request that HHSC calculate the recoupment prevention payment ceiling in accordance with the exception authorized by federal law. HHSC will adhere to CMS' determination on eligibility for exception authorized by Section 1923(g) of the Social Security Act whenever available.

(4) State Payment Cap.

(A) For program periods beginning October 1, 2022, HHSC will determine the lesser of between the two payment ceilings described in paragraphs (2) and (3) of this subsection. The lesser of the two payment ceilings will constitute the State Payment Cap for the DSH program.

(B) For program periods beginning on or after October 1, 2019 and ending on or before September 30, 2022, the state payment cap is described in paragraph (2) of this subsection.

(C) For program periods beginning on or after October 1, 2017 and ending on or before September 30, 2019, the state payment cap uses the costs in paragraph (2)(A) of this subsection and the payments 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.

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

(5) 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 (f)(1)(A)-(D), except that HHSC will:

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

(ii) Include supplemental payments (including upper payment limit payments) and uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributable to the hospital for the program year when calculating the total payments to be subtracted form total costs as described in (f)(3)(A);

(iii) Use the hospital's actual charge and payment data for services described in (f)(1)(A) and (B) provided to Medicaid- enrolled 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.

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

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

(C) A hospital that believes that it qualifies for an exception authorized by Section 1923(g) of the Social Security Act may request that HHSC or its contractors calculate the HSL in accordance with the exception authorized by federal law. HHSC will adhere to CMS' determination on eligibility for exception authorized by Section 1923(g) of the Social Security Act whenever available. The following conditions and procedures will apply to all such requests received by HHSC or its contractors.

(i) The hospital must submit its request in writing to HHSC within 90 days of the end of the federal fiscal year, and the request must include any and all necessary data and justification necessary for the determination of the eligibility of the hospital to receive the exception.

(ii) If HHSC approves the request, HHSC or its contractors will calculate the HSL using the methodology authorized under federal law.

(iii) HHSC will notify the hospital of the results of the HSL calculation in writing.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued) Distribution of available DSH funds

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

(1) State-owned hospitals. HHSC may reimburse state-owned teaching hospitals, state- owned IMDs, and public health hospitals an amount less than or equal to its state payment caps, except that aggregate payments to IMDs statewide may not exceed federally mandated reimbursement limits for IMDs.

(2) Rural public hospitals. HHSC will set aside an amount for rural public hospitals. While the funds are set aside before the non-state hospital funding, the payments will be calculated for each hospital after the non-state hospital payments are calculated.

(3) Rural private hospitals. If funds remain from the amount set aside in subsection (g)(2) of this section for rural public hospitals after paying all hospitals up to their state payment caps, HHSC may set aside a portion of the remaining federal funds for rural private hospitals.

(4) Non-state hospitals. HHSC distributes the remaining available DSH funds, if any, to other qualifying hospitals using the methodology described in subsection (h) of this section, including rural public and rural private hospitals. 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), and (2), and (3) of this subsection or the sum of remaining qualifying hospitals' state payment caps.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(h) DSH payment calculation.

(1) Data verification. HHSC uses the 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. The verification process includes:

(A) data sources for the application will include but not limited to Tax Assessor Receipts/Invoices or other official documentation of tax revenue/statements, Medicare Cost Report, and third-party data sources;

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

(C) 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 (g)(3), 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.

(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)(3) 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 transferring public hospitals as defined in subsection (b) of this section; or non-urban public hospital as defined in subsection (b) of this section 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 own and operate transferring public hospitals 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.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

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

(I) Non-urban public hospitals. Each governmental entity that operates or is under a lease contract with a non-urban public hospital is responsible for funding the non-federal share of the hospital's DSH payments from Pool Two (calculated as described in paragraphs (3) and (4) of this subsection) to that hospital.

(II) Transferring public hospitals. Each governmental entity that owns and operates a transferring public hospital is responsible for funding the non-federal share of the DSH payments from Pool Two (calculated as described in paragraphs (3) and (4) of this subsection) to its affiliated hospital, a portion of the non-federal share of the DSH payments from Pool Two to private hospitals, and a portion of the non-federal share of the rural private pool. For funding payments to private hospitals, HHSC will initially suggest an amount in proportion to each transferring public hospitals' individual state payment cap relative to total state payment caps for all transferring public hospitals. If an entity transfers less than the suggested amount, HHSC will take the steps described in paragraph (4)(H) of this subsection.

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

(3) Distribution and payment calculation for Pools One and Two initial payment, Standard DSH payment.

(A) HHSC will first determine the state payment cap for the hospital, as the maximum payment amount, as applied to interim payments that will be made for the program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured, including any year-to-date uncompensated-care (UC) payments attributable to the state payment cap.

(B) All hospitals that meet DSH qualification and eligibility criteria will be allocated an initial payment from Pools One and Two. Initial payments will be allocated as follows.

(i) A hospital will receive a payment that is the greater of:

(I) the hospital’s Medicaid shortfall; or

(II) a standard DSH payment.

(ii) If the amount calculated in clause (i) of this subparagraph is greater than the hospital’s state payment cap after considering the state share required to fund the standard DSH payment, the hospital will receive their state payment cap.

(C) HHSC will determine the standard DSH payment amount described in subparagraph (B)(i)(II) of this paragraph annually in an amount not to exceed $10,000,000 per hospital for hospitals that have reported residents on their Medicare cost report or in an amount not to exceed $10,000,000 per hospital for hospitals that have not reported residents on their Medicare cost report.

(D) For a privately-owned institution of mental disease their minimum payment amount may be reduced to ensure that payments for all IMDs remain below the IMD cap.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(4) Distribution and payment calculation for Pools One and Two secondary payment percentage of costs covered.

(A) The costs considered for the percentage of costs covered will be the costs included in the state payment cap in paragraph (3)(A) of this subsection.

(B) The payments considered for the percentage of costs covered will be the payments included in the state payment cap in paragraph (3)(A) of this subsection plus the standard DSH payment after considering the state share required to fund the hospital's payment. Transferring hospitals will not have IGT paid for private hospitals for the standard DSH payment included in their percentage of cost covered.

(C) The hospital's percentage of cost covered will be equal to the payments in subparagraph (B) of this paragraph divided by the cost in subparagraph (A) of this paragraph.

(D) HHSC will determine an allocation percentage such that all hospitals receive a uniform percentage of their costs covered to fully utilize Pools One and Two, Pass Two.

(E) If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for a Pool One and Two secondary payment.

(F) If a hospital's percentage of cost covered is lower than the allocation percentage, it will be allocated a projected payment such that its percentage of cost covered is equal to the uniform percentage in subparagraph (D) of this paragraph.

(G) 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)(I) of this subsection, HHSC will reduce that portion of the hospital's Pool Two payment to the level supported by the amount of the intergovernmental transfer.

(H) If a governmental entity that owns and operates a transferring public hospital does not fully fund the amount described in paragraph (2)(C)(iii)(II) of this subsection, HHSC will take the following steps.

(i) Provide an opportunity for the governmental entities affiliated with the other transferring public hospitals to transfer additional funds to HHSC.

(ii) Recalculate total Pool Two and rural private payments for transferring public hospitals and private hospitals based on actual IGT provided by each transferring public hospital using a methodology determined by HHSC.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

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

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

(i) For each transferring public hospital:

(I) Divide the Pool Two payments from paragraphs (3) and (4) of this subsection by the FMAP for the program year; and

(II) Multiply the result from subclause (I) 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) divide the Pool Two payments from paragraphs (3) and (4) of this subsection by the FMAP for the program year; and

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

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

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(B) HHSC will calculate the secondary payment from Pool Three for each transferring public hospital as follows:

(i) Sum the DSH payments from Pool Two to private hospitals..

(ii) Determine the transferring public hospital's state payment cap as a percentage of the total state payment caps for all transferring public hospitals.

(iii) Multiply the result of clause (i) of this subparagraph, the result of (ii), and the non-federal percentage.

(iv) Divide the result of clause (iii) of this subparagraph by the FMAP . The result is the Pass One secondary payment from Pool Three for that hospital.

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

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

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

(6) Pass Two - Secondary redistribution of amounts in excess of state payment caps for Pool Three. For each hospital that received a Pass One initial or secondary payment from Pool Three, HHSC will sum the results from (g)(4) and (g)(5) to determine the hospital's total projected DSH payment. In the event this sum plus any previous payment amounts for the program year exceeds a hospital's state payment cap, 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 state payment caps. 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 state payment cap;

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 the state payment cap;

(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.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(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.

(7) Rural public hospital pool distribution and payment calculation.

(A) For each rural public hospital, HHSC will calculate the Rural Public Hospital Maximum Payment before Limiting to Available Funds as follows:

(i) Determine the state payment cap in accordance with (h)(3)(A).

(ii) Subtract the payment amount from Pools One, Two, and Three after Pass Two in paragraph (6)(C)(ii)(III).

(B) The rural public hospital's maximum payment amount from subparagraph (A) of this paragraph is divided by the total rural public hospital maximum payment for all rural public hospitals to calculate the hospital's percentage of the total rural public pool.

(C) The percentage from subparagraph (B) of this paragraph will be multiplied by the lesser of the Rural public hospitals set-aside described in (g)(2) or the total rural public maximum payment in subparagraph (A) of this paragraph.

(D) Each rural public hospital is responsible for funding the rural public payment multiplied by the non-federal percentage. If the hospital does not fully fund the rural public payment, HHSC will reduce the hospital's rural public payment to the level supported by the amount of the intergovernmental transfer.

(8) Rural private hospital pool distribution and payment calculation.

(A) If any funds remain from the rural public pool described in paragraph (7) of this subsection, for each rural private hospital, HHSC will calculate a Private Rural Hospital Maximum Payment before Limiting to Available Funds as follows:

(i) Determine the state payment cap in accordance with (h)(3)(A).

(ii) Subtract the payment amount from Pools One, Two, and Three after Pass Two for each rural private hospital.

(B) The rural private hospital's maximum payment amount from subparagraph (A) of this paragraph is divided by the total rural private hospital maximum payment for all rural private hospitals to calculate the hospital's percentage of the total rural private pool.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(C) The percentage from subparagraph (B) of this paragraph will be multiplied by the lesser of the Rural private hospitals pool described in subsection (g)(3) or the total rural private maximum payment in subparagraph (A) of this paragraph.

(D) Each governmental entity that owns and operates a transferring public hospital is responsible for funding the non-federal share of the DSH payments from the rural private hospital pool to rural private hospitals. If an entity transfers less than the suggested amount, HHSC will reduce the rural private hospitals' payments to the level supported by the amount of the intergovernmental transfer.

(E) Any remaining federal funds will be redistributed back into the pool two secondary payment as described in paragraph (4) of this subsection. The remaining federal funds are calculated as follows:

(i) Determine the federal portion of the funds set aside in subsection (g)(2) by multiplying the amount in (g)(2) by the FMAP.

(ii) From the amount in clause (i), subtract the federal portion of the rural public payment calculated in paragraph (7)(C). The federal portion of the rural public payment is the total payments in paragraph (7)(C) less the total non-federal share calculated in (7)(D).

(iii) From the amount remaining in clause (ii), subtract the rural private total payments in paragraph (8)(C).

(9) Pass Three - If any portion of the non-federal share of the available DSH funds is not fully funded, the remaining allocation will be available to non-urban public hospitals that met the funding requirements described in paragraph (2)(C)(iii)(I) of this subsection.

(A) For each non-urban public hospital that met the funding requirements described in paragraph (2)(C)(iii)(I) 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) - (8) 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.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(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 non-urban public 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 DSH funds by subtracting payment amounts for all DSH hospitals calculated in ((4) - (8) of this subsection from the amount in subsection (g)(3) 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 DSH funds from clause (i) of this subparagraph by the total additional allocation 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) Non-urban public hospitals that do not meet the funding requirements of paragraph (2)(C)(iii)(I) of this subsection are not eligible for participation on Pass Three.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(10) Reallocating funds if a hospital closes, loses its license or eligibility, or files bankruptcy. If a hospital closes, loses its license, or 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 to state hospitals then amongst all DSH hospitals in the same category that are eligible for additional payments.

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

(12) 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 non-state owned IMDs are reduced first on a pro-rata basis so that the sum is equal to the federal IMD limit. In the case that the non-state owned IMD payments are eliminated and the payments for the state owned IMD still exceed the federal IMD limit, then the state owned IMD payments will be reduced on a pro-rata basis until they equal the federal IMD limit.

(13) For any DSH program year for which HHSC has calculated the hospital-specific limit described in subsection (f)(4) of this section, HHSC will compare the interim DSH payment amount as calculated in subsection (h) of this section to the hospital-specific limit.

(A) HHSC will limit the payment amount to the hospital-specific limit if the payment amount exceeds the hospital's hospital-specific limit.

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

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

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

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(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) - (9) 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 Finance, Provider Finance 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.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(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 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.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(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 will 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 in accordance with subsection (p) that received interim payments, subject to the hospital-specific limits, as described in subsections (f) 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 Provider Finance 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.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(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.

(p) Redistribution of Recouped Funds. Following the recoupments described in subsection (o) of this section, HHSC will redistribute the recouped funds to eligible providers. To receive a redistributed payment, the hospital must be in compliance with all requirements during the program year, meet the audit requirements described in subsection (o) of this section, and have already received a DSH payment in that DSH year of at least one dollar. For purposes of this subsection, an eligible provider is a provider that has room remaining in its final remaining Hospital-specific limit (HSL) calculated in the audit findings described in subsection (o) of this section after considering all DSH payments made for that program year. Recouped funds from state providers will be redistributed proportionately to eligible state providers based on the percentage that each eligible state provider's remaining final HSL (calculated in the audit findings as described in subsection (o) of this section) is of the total remaining final HSL (calculated in the audit findings described in subsection (o) of this section) of all eligible state providers. Recouped funds from non-state providers may be redistributed proportionately to state providers or eligible non-state providers as follows.

(1) For DSH program years 2011-2017 (October 1, 2011 – September 30, 2017) and for DSH program years 2020 and after (October 1, 2019 and after), HHSC will use the following methodology to redistribute recouped funds:

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

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

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

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(2) For DSH program years 2018-2019 (October 1, 2017 – September 30, 2019), HHSC will use the following methodology to redistribute recouped funds.

(A) To calculate a weight that will be applied to all non-state providers, HHSC will divide the final hospital-specific limit described in (f)(4) by the final hospital-specific limit described in (f)(4) of this division that has not offset payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer. HHSC will add 1 to the quotient. Any non-state provider that has a resulting weight of less than 1 will receive a weight of 1.

(B) HHSC will make a first pass allocation by multiplying the weight described in subsection (p)(2)(A) of this section by the final remaining HSL calculated in the audit findings described in subsection (o) of this section. HHSC will divide the product by the total remaining HSLs for all non-state providers. HHSC will multiply the quotient by the total amount of recouped dollars available for redistribution described in subsection (p)(1) of this section.

(C) After the first pass allocation, HHSC will cap non-state providers at its final remaining HSL. A second pass allocation will occur in the event non-state providers were paid over its final remaining HSL after the weight in subsection (p)(2)(A) of this section was applied. HHSC will calculate the second pass by dividing the final remaining HSL calculated in the audit findings described in subsection (o) of this section by the total remaining HSLs for all non-state providers after accounting for first pass payments. HHSC will multiply the quotient by the total amount of funds in excess of total HSLs for non-state providers capped at its total HSL.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(q) Interim Advance Payments

(1) In a DSH program year in which payments will be delayed pending data submission or for other reasons, HHSC may make interim advance payments to hospitals that meet the eligibility requirements described in subsection (c) of this section, meet a qualification in subsection (d) of this section, meet the conditions of participation in subsection (e) of this section, and submitted an acceptable disproportionate share hospital application for the preceding DSH program year from which HHSC calculated an annual maximum disproportionate share hospital payment amount for that year.

(2) Interim advance payments are considered to be prior period payments.

(3) A hospital that did not submit an acceptable disproportionate share hospital application for the preceding DSH program year is not eligible for an interim advance payment.

(4) If a partial year disproportionate share hospital application was used to determine the preceding DSH program year's payments, data from that application may be annualized for use in computation of an interim advance payment amount.

(5) The amount of the interim advance payments:

(A) are divided into three payments prior to a hospital receiving its final DSH payment amount;

(B) in DSH program years 2020 and after a provider that received a payment in the previous DSH program year is eligible to receive an interim advanced payment, and the calculations for interim advance payment 1, 2, and 3 are as follows:

(i) HHSC determines a percentage of the pool to pay out in the interim advanced payments; and

(ii) (ii) the pool amount is fed through the previous DSH program year calculation to determine the interim advance payments;

(C) in DSH program year 2024, HHSC will run the application data for hospital applications through an updated DSH qualification and calculation file to determine interim advanced payment eligibility and amount to account for rule changes between program year 2023 and 2024 to prevent recoupments; and

(D) HHSC will determine the payment allocation for the interim advances for 2025 and subsequent years by calculating a percentage based on a hospital's payment in the preceding year divided by the sum of all other hospitals' payment in the preceding year that are eligible for an interim advance payment.