TO: Hospital Payment Advisory Committee

DATE: June 10, 2021

FROM: Rene Cantu, Director of Hospital Provider Finance

Agenda Item No.: 3

SUBJECT: Disproportionate Share Hospital Reimbursement Methodology

Amendment to: Section 355.8065, Disproportionate Share Hospital Reimbursement Methodology

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

The Texas Health and Human Services Commission (HHSC) proposes to amend §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology.

Historically, HHSC has allowed State Institutions for Mental Diseases (IMDs) to participate in the Disproportionate Share Hospital (DSH) program, and they are treated in the same way as state hospitals. However, the rule does not explicitly reference State IMDs, or that State IMDs have been recognized as providers for years. The amendment broadens the definition of state-owned hospitals to include these hospitals.

The definition of Urban public hospital – Class one is being amended to clarify that the providers in this class must be owned and operated by an entity listed in the definition.

The DSH rule currently requires providers to maintain a Trauma system designation or actively pursue one, but there are several providers that do not have them because this designation does not fit the hospital's function. Children's hospitals, IMDs, and State IMDs generally fall into this misalignment category. The rule makes no mention of an exemption for these providers, and HHSC the amendment will explicitly exempt these providers.

The DSH rule has no provision for the DSH advanced payment methodology and leaves it up to HHSC's discretion. The Provider Finance Department has been using a methodology for several years to accomplish this payment and the proposal incorporates the established methodology into the rule.

The existing rule provides that HHSC can redistribute recouped funds to eligible providers but does not describe the method of the calculation. HHSC is proposing two methods of calculation. The first method will be used in DSH years 2011-2017

and 2020 and after and would redistribute funds proportionately to remaining Hospital Specific Limit (HSL) room for eligible hospitals.

For DSH years 2018-2019 HHSC will use a second method. Recouped funds from non-state providers will be redistributed to eligible providers using a weighted allocation methodology. First, HHSC will calculate a weight that will be applied to all providers. The weight is calculated based on the provider's final remaining HSL with and without the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer to determine how significantly the provider's HSL was impacted by not offsetting these payments. Providers who did not have a significant change in their HSL will receive a larger weight.

After calculating the weighting factor, HHSC will make a first pass allocation by multiplying the weight by the provider's final remaining HSL with the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer. HHSC will divide the product by the total remaining HSLs for all providers and multiply the quotient by the total amount of recouped dollars available for redistribution. HHSC will limit a provider's payment to the amount of the provider's final remaining HSL. If a provider is allocated a payment amount that is higher than its remaining HSL, HHSC will make a second pass allocation to redistribute the excess funds using the remaining HSL for all providers without applying the weight.

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 reconciliation described in §355.8065(q) is of the total remaining final HSL of all eligible state providers.
The low-income utilization rate (LIUR) is a ratio that represents the hospital’s volume of inpatient charity care relative to total inpatient services. As currently defined, several providers have a LIUR of over one hundred percent, and HHSC proposes to amend the rule to address this. The rule is also being amended to align with federal statute.

LIUR methodology currently inflates the LIUR for providers and results in unreasonably large LIURs guaranteeing qualification. The federal LIUR methodology better represents a provider’s low-income utilization and results in more accurate qualifications. Accordingly, fewer providers qualify solely on their LIUR; however, providers may still qualify for DSH with one of the other two qualifications. A potential issue that could arise is the possibility of some providers not qualifying that would have qualified under the previous LIUR.

ISSUES AND ALTERNATIVES:

None.

STAKEHOLDER INVOLVEMENT:

Comments on the proposed rule will be reviewed and evaluated during the comment period.

FISCAL IMPACT:

☒ None

RULE DEVELOPMENT SCHEDULE:

March 2021	Publish proposed rules in *Texas Register*
May 2021	Publish adopted rules in *Texas Register*
May 15, 2021	Effective date
June 10, 2021	Present to the Medical Care Advisory Committee
June 24, 2021	Present to HHSC Executive Council

REQUESTED ACTION: (Check appropriate box)

☐ The HPAC recommends approval of the proposed rules for publication.

☒ 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 an amendment to §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology.

BACKGROUND AND PURPOSE

The Disproportionate Share Hospital (DSH) program payments are made by HHSC to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals. Federal law also limits FFP for DSH payments through the hospital-specific DSH limit. In Texas, the state has established a State Payment Cap that limits the amount of payments that a provider receives through the interim payment process. This proposal amends the definitions of certain provider classes, describes a methodology for redistribution of certain recouped funds, modifies the calculation of the low-income utilization rate to reflect federal law, and makes other clarifying amendments.

Provider Class Definitions
Historically, HHSC has allowed state institutions for mental diseases (IMDs) to participate in the DSH program. However, the rule does not explicitly reference State IMD participation nor the fact that state IMDs have been recognized as state-owned providers for many years. The rule proposal will amend the definition of state-owned hospitals to be broader and include these hospitals.

The definition of Urban public hospital – Class one is being amended to clarify that the providers in this class must be owned and operated by an entity listed in the definition.

Methodology for Redistribution of Recouped Funds
The existing rule provides that HHSC can redistribute recouped funds to eligible providers but does not describe the method of the calculation. HHSC is proposing two methods of calculation. The first method will be used in DSH years 2011-2017 and 2020 and after and would redistribute funds proportionately to remaining Hospital Specific Limit (HSL) room for eligible hospitals.

For DSH years 2018-2019 HHSC will use a second method. Recouped funds from non-state providers will be redistributed to eligible providers using a weighted allocation methodology. First, HHSC will calculate a weight that will be applied to all providers. The weight is calculated based on the provider's final remaining HSL with

and without the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer to determine how significantly the provider's HSL was impacted by not offsetting these payments. Providers who did not have a significant change in their HSL will receive a larger weight.

After calculating the weighting factor, HHSC will make a first pass allocation by multiplying the weight by the provider's final remaining HSL with the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer. HHSC will divide the product by the total remaining HSLs for all providers and multiply the quotient by the total amount of recouped dollars available for redistribution. HHSC will limit a provider's payment to the amount of the provider's final remaining HSL. If a provider is allocated a payment amount that is higher than its remaining HSL, HHSC will make a second pass allocation to redistribute the excess funds using the remaining HSL for all providers without applying the weight.

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 reconciliation described in §355.8065(q) is of the total remaining final HSL of all eligible state providers.

Low-Income Utilization Rate Calculation
The low-income utilization rate (LIUR) is a ratio that represents the hospital's volume of inpatient charity care relative to total inpatient services. As currently defined, several providers have a LIUR over one hundred, and the rule is being amended to address this. The rule is also being amended to align with federal statute.

Other Clarifications
The DSH rule requires providers to maintain a Trauma system designation or actively pursue one, but several providers do not have a Trauma system designation because the designation does not fit the hospital's function. Children's hospitals, IMDs, and State IMDs generally fall into this misalignment category. The rule makes no mention of an exemption for these providers, though it has been established practice to exempt them from this requirement, and HHSC proposes an amendment to explicitly exempt these providers.

The DSH rule currently has no provision for the DSH advanced payment methodology and leaves it up to HHSC's discretion. The Provider Finance Department has been using a methodology for several years to accomplish this payment and the proposal incorporates the established methodology into the rule.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.8065(b)(15) adds the abbreviation "(HSL)" to the term "Hospital-specific limit."

The proposed amendment to §355.8065(b) adds a new definition "State institution of mental disease (State IMD)" to define an ownership type that was not defined previously. The paragraphs are renumbered to account for the addition.

The proposed amendment to §355.8065(b)(39) replaces the term "State-owned teaching hospital" with "State-owned hospital."

The proposed amendment to §355.8065(b)(45) updates references.

The proposed amendment to §355.8065(b)(46) deletes text and adds "owned and operated" to the definition of "Urban Public Hospital – Class One." There are proposed conforming amendments to §355.8065(h)(2)(C) and (h)(5)(F).

The proposed amendment to §355.8065(b)(47) makes a minor edit for clarity.

The proposed amendment to §355.8065(d)(2) deletes clauses (i) and (ii) and subparagraph (B). Subparagraph (A) is updated and combined with paragraph (2). The edits are made to align with federal statute.

The proposed amendment to §355.8065(d)(4) updates the term by adding "State IMDs" as a new hospital type that is deemed to qualify and deletes the term "teaching" to describe "hospitals" in this paragraph.

The proposed amendment to §355.8065(e)(3) adds subparagraph (C) to exempt Children's Hospitals, IMDs, and State IMDs from this condition of participation.

An edit is made to §355.8065(h)(2)(B)(ii) to update a reference to a definition.

The proposed amendment to §355.8065 adds subsections (p), Recoupment; (q), Reconciliation; (r), Redistribution of Recouped Funds; and (s), Advance Payments in order to document methodology and procedures that are in current practice. Proposed conforming amendments are made to 355.8065(l) and (o)(1)(E).

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local governments as a result of enforcing and administering the rule as proposed.

GOVERNMENT GROWTH IMPACT STATEMENT

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

(1) the proposed rule will not create or eliminate a government program;
(2) implementation of the proposed rule will not affect the number of HHSC employee positions;

(3) implementation of the proposed rule will not require an increase in future legislative appropriations;
(4) the proposed rule will not affect fees paid to HHSC;
(5) the proposed rule will not create a new rule;
(6) the proposed rule will expand an existing rule;
(7) the proposed rule will not change the number of individuals subject to the rule; and
(8) the proposed rule will not affect the state's economy.

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because this rule does not impose cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public will benefit from the adoption of the rule because of the increased transparency in the new provisions included in the rule.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because the rule does not impose any additional fees or costs on those who are required to comply.

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

A public hearing to receive comments on the proposal will be held by HHSC through a webinar. The meeting date and time will be posted on the HHSC Communications

and Events Website at https://hhs.texas.gov/about-hhs/communications-events and the HHSC Provider Finance Hospitals website at https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/disproportionate-share-hospitals.

If you have questions, please contact Rene Cantu at UCTools@hhsc.state.tx.us.

PUBLIC COMMENT

Written comments on the proposal may be submitted to the HHSC Provider Finance Department, 4900 North Lamar Blvd., Austin, TX 78751 (Mail Code H-400); P.O. Box 149030, Austin, TX 78714-9030 (Mail Code H-400); by fax to (512)-730-7475; 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 emailed 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 emailing comments, please indicate "Comments on Proposed Rule 21R078" in the subject line.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; 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-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32.

The amendment affects 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 Rene Cantu at (737) 203-7842 or email Al Anthony in the HHSC Provider Finance for Hospitals department at UCTools@hhsc.state.tx.us.

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 (HSL) --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 calculated using the methodology described in §355.8066 of this title (relating to Hospital-Specific Limit Methodology) 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 institution for mental diseases (State IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness and that is owned and operated by a state university or other state agency.

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

(41) [~~(40)~~] 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. The state payment cap is calculated using the methodology described in §355.8066 of this title (relating to Hospital-Specific Limit Methodology) using interim cost and payment data from the DSH data year.

(42) [~~(41)~~] 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.

(43) [~~(42)~~] 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.

(44) [~~(43)~~] 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.

(45) [~~(44)~~] 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.

(46) [~~(45)~~] Urban public hospital--Any of the urban hospitals listed in paragraph (47) [~~(46)~~] or (48) [~~(47)~~] of this subsection.

(47) [~~(46)~~] Urban public hospital - Class one--A hospital that is owned and operated [~~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.

(48) [~~(47)~~] 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 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 as described in the Social Security Act §1923(b)(3). [~~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, and State IMDs 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.

(C) The following hospital types are exempted from the condition of participation described in this paragraph: Children’s Hospitals, IMDs, 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 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) State payment cap and hospital-specific limit calculation. HHSC uses the methodology described in §355.8066 of this title to calculate a state payment cap for each Medicaid hospital that applies and qualifies to receive payments for the DSH program year under this section, and a 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 state payment cap 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 state payment caps, 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' state payment

caps.

(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)(46) [~~(b)(45)~~] 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 own and operate [~~or are under lease contracts with~~] Urban public hospitals - Class one, governmental entities that operate or are under lease contracts with an Urban public hospital -

[~~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 <u>owns and</u> 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 state payment cap relative to total state payment caps 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 amount of third party commercial insurance payments for that hospital from the DSH data year by the state payment cap calculated according to §355.8066(c)(1)(D)(ii)(I)(-b-), except that costs are reduced by payments from all payors.

(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 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 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 state payment caps 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 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 state payment cap. 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 state payment caps. 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 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 their 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.

(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 owns and 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 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 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 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 state payment cap. 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 their 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.

(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 state payment cap 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 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 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 their 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 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 §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 and redistribution of DSH funds. As described in subsection (p) of [~~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 as described in subsection (r) of this section. [~~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 as described in this subsection and will redistribute the recouped funds to DSH providers that are eligible for additional payments, subject to their [~~the~~] hospital-specific limits, as described in subsections [~~subsection~~] (l) and (r) 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.

(p) Recoupment.

(1) In the event of an overpayment identified by HHSC, or its contractor, or a disallowance by CMS of federal financial participation related to a hospital's receipt or use of payments under this section, HHSC may recoup an amount equal to the amount of the overpayment or disallowance.

(2) Payments under this section may be subject to adjustment for payments

made in error, including, without limitation, adjustments under §371.1711 of this title (relating to Recoupment of Overpayments and Debts), 42 CFR Part 455, and the Texas Government Code Chapter 403. HHSC may recoup an amount equivalent to any such adjustment.

(3) HHSC may recoup from any current or future Medicaid payments as follows.

(A) HHSC will recoup from the hospital against which any overpayment was made or disallowance was directed.

(B) If, within 30 days of the hospital's receipt of HHSC's written notice of recoupment, the hospital has not paid the full amount of the recoupment or entered into a written agreement with HHSC to do so, HHSC may withhold any or all future Medicaid payments from the hospital until HHSC has recovered an amount equal to the amount overpaid or disallowed.

(q) Reconciliation. HHSC will reconcile actual costs incurred by the hospital for the demonstration year with disproportionate share hospital (DSH) payments, if any, made to the hospital for the same period:

(1) if a hospital received payments in excess of its actual costs, the overpaid amount will be recouped from the hospital, as described in subsection (o) of this section; and

(2) if a hospital received payments less than its actual costs, and if HHSC has available DSH funding for the DSH program year in which the costs were accrued, the hospital may receive reimbursement for some or all of those actual documented unreimbursed costs.

(r) Redistribution of Recouped Funds. Following the recoupments described in subsection (p) of this section, HHSC will redistribute the recouped funds to eligible providers. For purposes of this subsection, an eligible provider is a provider who has room remaining in its final remaining Hospital-specific limit (HSL) calculated in the reconciliation described in subsection (q) of this section after considering all DSH payments made for that DSH 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 reconciliation as described in subsection (q) of this section) is of the total remaining final HSL (calculated in the reconciliation described in subsection (q) 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 years 2011-2017 (October 1, 2011 – September 30, 2017) and for DSH 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 DSH program year;

(B) the federal share will be distributed proportionately among all 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.

(2) For DSH 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 providers, HHSC will divide the final hospital-specific limit described in §355.8066(c)(2) of this chapter (relating to Hospital-Specific Limit Methodology) by the final hospital-specific limit described in §355.8066(c)(2) of this chapter 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 provider who 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 subparagraph (A) of this paragraph by the final remaining HSL calculated in the reconciliation described in subsection (q) of this section. HHSC will divide the product by the total remaining HSLs for all 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 providers at their final remaining HSL. A second pass allocation will occur in the event providers were paid over their final remaining HSL after the weight in subparagraph (A) of this paragraph was applied. HHSC will calculate the second pass by dividing the final remaining HSL calculated in the reconciliation described in subsection (q) of this section by the total remaining HSLs for all providers after accounting for first pass payments. HHSC will multiply the quotient by the total amount of funds in excess of total HSLs for providers capped at their total HSL.

(s) Advance Payments

(A) In a DSH program year in which payments will be delayed pending data submission or for other reasons, HHSC may make 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.

(B) Advance payments are considered to be prior period payments.

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

(D) 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 advance payment amount.

(E) The amount of the advance payments:

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

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

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

(II) the pool amount is fed through the previous DSH program year calculation to determine the advanced payments.