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**State/Territory Name: Texas**

**State Plan Amendment (SPA) #: TX 21-0032**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, MD 21244-1850



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**Financial Management Group**

April 12, 2022

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

RE: Texas State Plan Amendment (SPA) 21-0032

Dear Ms. Stephens:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 21-0032 effective for services on or after September 1, 2021. This amendment revises the inpatient hospital services reimbursement pages of the State Plan to enhance clarity, modify the policy for updating the Diagnosis Related Group (DRG) statistical calculations, and add requirements for a biennial review of rural hospital rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 21-0032 is approved effective September 1, 2021. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,

A handwritten signature in cursive script that reads "Rory Howe".

Rory Howe  
Director

Enclosure

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER: <b>21-0032</b>	2. STATE: <b>TEXAS</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: September 1, 2021	
5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <b>Title XIX of the Social Security Act</b> <b>42 CFR §440.10 and 42 CFR §440.20</b>		7. FEDERAL BUDGET IMPACT: <b>NO FINANCIAL IMPACT</b> * Figures in the thousands a. FFY 2022 - \$0* b. FFY 2023 - \$0* c. FFY 2024 - \$0*	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>SEE ATTACHMENT TO BLOCK 8 &amp; 9</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>SEE ATTACHMENT TO BLOCK 8 &amp; 9</b>	
10. SUBJECT OF AMENDMENT: The proposed amendment revises the inpatient hospital services reimbursement pages of the State Plan to enhance clarity, modify the policy for updating the DRG statistical calculations, and add requirements for a biennial review of rural hospital rates.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:  Stephanie Stephens		16. RETURN TO: <b>Stephanie Stephens</b> <b>State Medicaid Director</b> <b>Post Office Box 13247, MC: H-100</b> <b>Austin, Texas 78711</b>	
13. TYPED NAME: <b>Stephanie Stephens</b>			
14. TITLE: <b>State Medicaid Director</b>			
15. DATE SUBMITTED: <b>September 30, 2021</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: September 30, 2021		18. DATE APPROVED: April 12, 2022	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: September 1, 2021		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Rory Howe		22. TITLE: Director, FMG	
23. REMARKS:			

## **METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- INPATIENT HOSPITAL SERVICES**

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to calculate reimbursement for a covered inpatient hospital service.

(b) Definitions.

- (1) Add-on--An amount that is added to the base Standard Dollar Amount (SDA) to reflect high-cost functions and services or regional cost differences..
- (2) Adjudicated--The approval or denial of an inpatient hospital claim by HHSC
- (3) Base standard dollar amount (base SDA)--A standardized payment amount calculated by HHSC, as described in subsections (c) and (d) of this section, for the costs incurred by prospectively-paid hospitals in Texas for furnishing covered inpatient hospital services.
- (4) Base year--For the purpose of this section, the base year is a state fiscal year (September through August) to be determined by HHSC.
- (5) Base year claims-- For the purposes of rate setting, including diagnosis related group (DRG) relative weights, mean length of stay (MLOS) and day thresholds, and rebasing or realignment of base rates effective September 1, 2021 and after, HHSC includes Medicaid inpatient fee-for-service (FFS) and MCO encounters that meet the criteria in subparagraphs (A) - (F) of this paragraph in the Base Year claims data. For base rates set prior to September 1, 2021, individual sets of base year claims are compiled for children's hospitals and urban hospitals for the purposes of rate setting and realignment. All Medicaid traditional fee-for-service (FFS) and Primary Care Case Management (PCCM) inpatient hospital claims for reimbursement filed by an urban or children's-a hospital that:
  - (A) had a date of admission occurring within the base year;
  - (B) were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such claims that had zero inpatient days;
  - (C) were not claims for patients who are covered by Medicare;
  - (D) were not Medicaid spend-down claims;
  - (E) were not claims associated with military hospitals, out-of-state hospitals, state owned teaching hospitals, and freestanding psychiatric hospitals; and
  - (F) Individual sets of base year claims are compiled for children's hospitals, and urban hospitals for the purposes of rate setting and rebasing.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 19-0026

Effective Date: 09-01-21

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- INPATIENT HOSPITAL SERVICES**

- (6) Children's hospital--A Medicaid hospital designated by Medicare as a children's hospital and exempted by the Centers for Medicare and Medicaid Services (CMS) from the Medicare prospective payment system.
- (7) Cost outlier payment adjustment--A payment adjustment for a claim with extraordinarily high costs.
- (8) Cost outlier threshold--One factor used in determining the cost outlier payment adjustment.
- (9) Day outlier payment adjustment--A payment adjustment for a claim with an extended length of stay.
- (10) Day outlier threshold--One factor used in determining the day outlier payment adjustment.
- (11) Diagnosis-related group (DRG)--The classification of medical diagnoses as defined in the 3M™ All Patient Refined Diagnosis Related Group (APR-DRG) system or as otherwise specified by HHSC.
- (12) Final settlement--Reconciliation of cost in the Medicare/Medicaid hospital fiscal year end cost report performed by HHSC within six months after HHSC receives the cost report audited by a Medicare intermediary or HHSC.
- (13) Final standard dollar amount (final SDA) --The rate assigned to a hospital after HHSC applies the add-ons and other adjustments described in this section.
- (14) Geographic wage add-on--An adjustment to a hospital's base SDA to reflect geographical differences in hospital wage levels. Hospital geographical areas correspond to the Core-Based Statistical Areas (CBSAs) established by the federal Office of Management and Budget in 2003.
- (15) HHSC--The Texas Health and Human Services Commission or its designee.
- (16) Impact file--The Inpatient Prospective Payment System (IPPS) Final Rule Impact File that contains data elements by provider used by the Centers for Medicare and Medicaid Services (CMS) in calculating Medicare rates and impacts. The impact file is publicly available on the CMS website.
- (17) Inflation update factor--Cost of living index based on the annual CMS Prospective Payment System Hospital Market Basket Index.
- (18) Inpatient Ratio of cost-to-charges (RCC)--A ratio that covers all applicable Medicaid hospital costs and charges relating to inpatient care.
- (19) In-state children's hospital--A hospital located within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.
- (20) Interim payment--An initial payment made to a hospital that is later settled to Medicaid- allowable costs for hospitals reimbursed under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 13-0036

Effective Date: 09-01-21

## **METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

### **HOSPITAL SERVICES (continued)**

- (21) Interim rate-The ratio of Medicaid allowed inpatient costs to Medicaid allowed inpatient charges filed on a hospital's Medicare/Medicaid cost report, expressed as a percentage. The interim rate established during a cost report settlement for an urban hospital or a rural hospital reimbursed under this section excludes the application of TEFRA target caps and the resulting incentive and penalty payments.
- (22) Managed Care Organization (MCO) Adjustment Factor—Factor used to estimate Managed Care premium tax, risk margin, and administrative costs related to contracting with HHSC. The estimated amounts are subtracted from appropriations.
- (23) Mean length of stay (MLOS)-One factor used in determining the payment amount calculated for each DRG;; the average number of inpatient days.
- (24) Medical education add-on-An adjustment to the base SDA for an urban teaching hospital to reflect higher patient care costs relative to non-teaching urban hospitals.
- (25) Military hospital-A hospital operated by the armed forces of the United States.
- (26) New Hospital-A hospital that was enrolled as a Medicaid provider after the end of the base year and has no base year claims data.
- (27) Out-of-state children's hospital-A hospital located outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.
- (28) Realignment—Recalculation of the base SDA and add-ons using current RCCs, inflation factors, and base year claims as specified by HHSC, or its designee, for one or more hospital types. Realignment will occur based on legislative direction.
- (29) Rebasing-Calculation of SDAs and add-ons, DRG relative weights, MLOS, and day outlier thresholds for all hospitals using a base period as specified by HHSC, or its designee. Rebasing will occur based on legislative direction.
- (30) Relative weight-The weighting factor HHSC assigns to a DRG representing the time and resources associated with providing services for that DRG.
- (31) Rural base year stays—An individual set of base year stays is compiled for rural hospitals for the purposes of rate setting and realignment. All inpatient FFS claims and inpatient Managed Care encounters for reimbursement filed by a rural hospital that:
  - (A) had a date of admission occurring within a base year;
  - (B) were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such stays that had zero inpatient days;
  - (C) were not stays for patients who are covered by Medicare; and
  - (D) were not Medicaid spend-down stays; and were not stays associated with military hospitals out-of-state hospitals, state-owned teaching hospitals, and freestanding psychiatric hospitals.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 17-0019

Effective Date: 09-01-21

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

**HOSPITAL SERVICES (continued)**

(32) Rural hospital-A hospital that:

(A) is located in a county with 60,000 or fewer persons based on the 2010 decennial census; or

(B) is designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or

(C) meets all of the following criteria:

(i) has 100 or fewer beds;

(ii) is designated by Medicare as a CAH, SCH, or RRC; and

(iii) is located in an MSA

(33) Safety-Net add-on-An adjustment to the base SDA for a safety-net hospital to reflect the higher costs of providing Medicaid inpatient services in a hospital that provides a significant percentage of its services to Medicaid and/or uninsured patients.

(34) Safety-Net hospital-An urban or children's hospital that meets the eligibility and qualification requirements described in Appendix 1 to Attachment 4.19-A (relating to Disproportionate Share Hospital Reimbursement Methodology) in the Texas State Medicaid Plan for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.

(35) Standard Dollar Amount (SDA)—A standardized payment amount calculated by HHSC, as described for the costs incurred by prospectively paid hospitals in Texas for furnishing covered inpatient hospital services.

(36) State-owned teaching hospital- Acute Care Hospital owned and operated by the state of Texas.

(37) Teaching hospital-A hospital for which CMS has calculated and assigned a percentage Medicare education adjustment factor under 42 CFR §412.105.

(38) Teaching medical education add-on-An adjustment to the base SDA for a children's teaching hospital with a program approved by the Accreditation Council for Graduate Medical Education (ACGME) to reflect higher patient care costs relative to non-teaching children's hospitals.

(39) TEFRA target cap-A limit set under the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) and applied to a hospital's cost settlement under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA target cap is not applied to services provided to patients under age 21, and incentive and penalty payments associated with this limit are not applicable to those services.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 17-0019

Effective Date: 09-01-21

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

**HOSPITAL SERVICES (continued)**

- (40) Tentative settlement-Reconciliation of cost in the Medicare/Medicaid hospital fiscal year-end cost report performed by HHSC within six months after HHSC receives an acceptable cost report filed by a hospital.
- (41) Texas provider identifier (TPI)-A unique number assigned to a provider of Medicaid services in Texas.
- (42) Trauma add-on-An adjustment to the base SDA for a trauma hospital to reflect the higher costs of obtaining and maintaining a trauma facility designation, as well as the direct costs of providing trauma services, relative to non-trauma hospitals or to hospitals with lower trauma facility designations. To be eligible for the trauma add-on, a hospital must be eligible to receive an allocation from the trauma facilities and emergency medical services account under Texas Health and Safety Code Chapter 780.
- (43) Trauma hospital-An inpatient hospital that meets the Texas Department of State Health Services criteria for a Level I, II, 111, or IV trauma facility designation.
- (44) Universal mean-Average base year cost per claim for all urban hospitals.
- (45) Urban hospital-Hospital located in a metropolitan statistical area and not fitting the definition of rural hospitals, children's hospitals, state-owned teaching hospitals, or freestanding psychiatric hospitals.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT  
HOSPITAL SERVICES (continued)**

- (c) Base children's (SDA) calculations. HHSC will use the methodologies described in this subsection to determine average statewide base SDA and final SDA for each children's hospital.
- (1) HHSC calculates the average base year cost per claim as follows.
- (A) To calculate the total inpatient base year cost per children's hospital:
- (i) sum the allowable inpatient charges by hospital for the base year claims; and
- (ii) multiply clause (i) of this subparagraph by the inpatient RCC and the inflation update factors to inflate the base year cost to the current year.
- (B) Sum the amount of all hospitals' base year costs from subparagraph (A) of this paragraph.
- (C) Subtract an amount equal to the estimated outlier payment amount for the base year claims for all children's hospitals from subparagraph (B) of this paragraph.
- (D) To derive the average base year cost per claim, divide the result from subparagraph (C) of this paragraph by the total number of base year claims.
- (2) HHSC calculates the base children's SDA as follows.
- (A). From the amount determined in paragraph (1)(C) of this subsection, HHSC sets aside an amount for add-ons as described in paragraph (3) of this subsection. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.
- (B) The amount remaining from paragraph (1)(C) of this subsection after HHSC sets aside the amount for add-ons in subparagraph (A) of this paragraph is then divided by the sum of the relative weights for all children's base year claims to derive the base SDA.
- (3) A children's hospital may receive increases to the base SDA for any of the following.
- (A) Add-on amounts, which will be determined or adjusted based on the following.
- (i) Impact files.
- (I) HHSC will use the most recent finalized impact file available at the time of realignment to calculate add-ons; and
- (II) HHSC will use the impact file in effect at the last realignment to calculate add-ons for new hospitals, except as otherwise specified in this section.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 15-0025

Effective Date: 09-01-21

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

**HOSPITAL SERVICES (continued)**

- (ii) Geographic wage reclassification. If a hospital becomes eligible for the geographic wage reclassification under Medicare, the hospital will become eligible for the adjustment upon the next realignment.
- (iii) Teaching medical education add-on during the fiscal year. If a hospital becomes eligible for the teaching medical education add-on the hospital will receive an increased final SDA to include these newly eligible add-ons, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year.
- (iv) Safety-net add-on during the fiscal year. The hospital will receive an increased final SDA to include these newly eligible add-ons, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year.
- (v) New children's hospital teaching medical education add-on. If an eligible children's hospital is new to the Medicaid program and a cost report is not available, the teaching medical education add-on will be calculated at the beginning of the state fiscal year after a cost report is received.

(B) Geographic wage add-on.

- (i) CBSA assignment. For claims with dates of admission beginning September 1, 2013, and continuing until the next realignment, the geographic wage add-on for children's hospitals will be calculated based on the corresponding CBSA in the impact file in effect on September 1, 2011.
- (ii) Designated impact file. Subsequent add-ons will be based on the impact file available at the time of realignment.
- (iii) Wage index. To determine a children's hospital geographic wage add-on, HHSC first calculates a wage index for Texas as follows.
  - (I) HHSC identifies the Medicare wage index factor for each CBSA in Texas.
  - (II) HHSC identifies the lowest Medicare wage index factor in Texas.
  - (III) HHSC divides the Medicare wage index factor in subclause (I) of this clause for each CBSA by the lowest Medicare wage index factor identified in subclause (II) of this clause and subtracts one from each resulting quotient.
- (iv) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification under the process described in subparagraph (E) of this paragraph.
- (v) Medicare labor-related percentage. HHSC uses the Medicare labor-related percentage available at the time of realignment.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 13-0036

Effective Date: 09-01-21

## **METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

### **HOSPITAL SERVICES (continued)**

(vi) Geographic wage add-on calculation. The final geographic wage add-on is equal to the product of the base SDA calculated in subsection (c)(2)(B) of this section, the wage index calculated in clause (iii)(III) of this subparagraph, and the Medicare labor-related percentage in clause (v) of this subparagraph.

(C) Teaching medical education add-on.

(i) Eligibility. A teaching hospital that is a children's hospital is eligible for the teaching medical education add-on. Each children's hospital is required to confirm, under the process described in subparagraph (E) of this paragraph, that HHSC's determination of the hospital's eligibility for the add-on is correct.

(ii) Teaching medical education add-on calculation.

(I) For each children's hospital, identify the total hospital medical education cost from each hospital cost report or reports that cross over the base year.

(II) For each children's hospital, sum the amounts identified in subclause (I) of this clause to calculate the total medical education cost.

(III) For each children's hospital, calculate the average medical education cost by dividing the amount from subclause (II) of this clause by the number of cost reports that cross over the base year.

(IV) Sum the average medical education cost per hospital to determine a total average medical education cost for all hospitals.

(V) For each children's hospital, divide the average medical education cost for the hospital from subclause (III) of this clause by the total average medical education cost for all hospitals from subclause (IV) of this clause to calculate a percentage for the hospital.

(VI) Divide the total average medical education cost for all hospitals from subclause (IV) of this clause by the total base year cost for all children's hospitals from subsection (c)(1)(B) of this section to determine the overall teaching percentage of Medicaid cost.

(VII) For each children's hospital, multiply the percentage from subclause (V) of this clause by the percentage from subclause (VI) of this clause to determine the teaching percentage for the hospital.

(VIII) For each children's hospital, multiply the hospital's teaching percentage by the base SDA amount to determine the teaching medical education add-on amount.

(D) Safety-Net add-on.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

**HOSPITAL SERVICES (continued)**

- (i) Eligibility. If a children's hospital meets the definition of a "safety-net hospital" as defined in subsection (b) of this section, it is eligible for a safety-net add-on.
- (ii) Add-on amount. HHSC calculates the safety-net add-on amounts annually or at the time of realignment as follows.
  - (I) For each eligible hospital, determine the following amounts for a period of 12 contiguous months specified by HHSC:
    - (-a-) total allowable Medicaid inpatient days for fee-for-service claims;
    - (-b-) total allowable Medicaid inpatient days for managed care encounters;
    - (-c-) total relative weights for fee-for-service claims; and
    - (-d-) total relative weights for managed care encounters.
  - (II) Determine the total allowable days for eligible safety-net hospitals by summing the amounts in items (-a-) and (-b-) of subclause (I) of this clause.
  - (III) Determine the hospital's percentage of total allowable days to the total in subclause (II) of this clause.
  - (IV) Determine the hospital's portion of appropriated safety-net funds before the MCO adjustment factor is applied by multiplying the amount in subclause (III) of this clause for each hospital by the total safety-net funds deflated to the data year.
  - (V) For each hospital, multiply item (-d-) of subclause (I) of this clause by the relevant MCO adjustment factor.
  - (VI) Sum the amounts in item (-c-) of subclause (I) of this clause and subclause (V) of this clause for each hospital.
  - (VII) To calculate the safety-net add-on, divide the amount in subclause (IV) of this clause by the amount in subclause (VI) of this clause for each hospital. The result is the safety-net add-on.
- (iii) Reconciliation. Effective for costs and revenues accrued on or after September 1, 2015, HHSC may perform a reconciliation for each hospital that received the safety-net add-on to identify any such hospitals with total Medicaid reimbursements for inpatient and outpatient services in excess of their total Medicaid and uncompensated care inpatient and outpatient costs. For hospitals with total Medicaid reimbursements in excess of total Medicaid and uncompensated care costs, HHSC may recoup the difference.
- (E) Add-on status verification.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 19-0026

Effective Date: 09-01-21

## **METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

### **HOSPITAL SERVICES (continued)**

- (i) Notification. HHSC will determine a hospital's initial add-on status by reference to the impact file at the time of realignment, Medicaid days, and relative weight information from HHSC's fiscal intermediary. HHSC will notify the hospital of the CBSA to which the hospital is assigned, the Medicare teaching hospital designation for children's hospitals as applicable, and any other related information determined relevant by HHSC. For state fiscal years 2017 and after, HHSC will also notify eligible hospitals of the data used to calculate the safety-net add-on. HHSC may post the information on its website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, or provide the information to the hospital associations to disseminate to their member hospitals.
  - (ii) Rate realignment. HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:
    - (I) the hospital provides documentation of its eligibility for a different teaching medical education add-on or teaching hospital designation.
    - (II) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA; or
    - (III) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.
  - (iii) Annual SDA calculation. HHSC will calculate a hospital's final SDA annually using the add-on status initially determined during realignment by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:
    - (I) the hospital provides documentation of new teaching program or new teaching hospital designation; or
    - (II) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on
  - (iv) Failure to notify. If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.
- (4) Final children's hospital SDA calculations. HHSC calculates a children's hospital's final SDA as follows.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 19-0026

Effective Date: 09-01-21

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

**HOSPITAL SERVICES (continued)**

- (A) Add all add-on amounts for which the hospital is eligible to the base SDA.
  - (B) For labor and delivery services provided to adults age 18 or greater in a children's hospital, the final SDA is equal to the base SDA for urban hospitals without add-ons, calculated as described in subsection (d)(4)(E)(i) of this section plus the urban hospital geographic wage add-on for an urban hospital located in the same CBSA as the children's hospital providing the service.
  - (C) For new children's hospitals that are not teaching hospitals, for which HHSC has no base year claim data, the final SDA is the base SDA plus the hospital's geographic wage add-on. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier
  - (D) For new children's hospitals that qualify for the teaching medical education add-on, as defined in subsection (b) of this section, for which HHSC has no base year claim data, the final SDA is calculated based on one of the following options until realignment is performed with base year claim data for the hospital. A new children's hospital must notify the HHSC Provider Finance Department of its selected option within 60 days from the date the hospital is notified of its provider activation by HHSC's fiscal intermediary. If notice of the option is not received, HHSC will assign the hospital the SDA calculated as described in clause (i) of this subparagraph. The SDA calculated based on the selected option will be effective retroactive to the first day of the provider's enrollment.
    - (i) Children's hospital base SDA plus the applicable geographic wage add-on and the minimum teaching add-on for existing children's hospitals. No settlement of costs is required for services reimbursed under this option. The SDA will be in effect for the hospital for three years or until the next realignment when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.
    - (ii) Children's base SDA plus the applicable geographic wage add-on and the maximum teaching add-on for existing children's hospitals. A cost settlement is required for services reimbursed under this option. The SDA will be in effect for the hospital for three years or until the next realignment when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.
- (d) Base urban hospital SDA calculations. HHSC will use the methodologies described in this subsection to determine the average statewide base SDA and the final SDA for each urban hospital.
- (1) HHSC calculates the average base year cost per claim (the universal mean) as follows.
    - (A) To calculate the total inpatient base year cost per urban hospital:
      - (i) sum the allowable inpatient charges by hospital for the base year claims; and

## METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

### HOSPITAL SERVICES (continued)

- (ii) multiply clause (i) of this subparagraph by the inpatient RCC and the inflation update factors to inflate the base year cost to the current year.
  - (B) Sum the amount for all hospitals' base year costs from subparagraph (A) of this paragraph.
  - (C) To derive the average base year cost per claim, divide the result from subparagraph (B) of this paragraph by the total number of base year claims.
- (2) HHSC calculates the base urban SDA as follows.
  - (A) From the amount determined in paragraph (1)(B)(A)(ii) of this subsection for urban hospitals, HHSC sets aside an amount for add-ons as described in paragraph (3) of this subsection. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.
  - (B) The amount remaining from paragraph (1)(B)(A)(ii) of this subsection after HHSC sets aside the amount for add-ons in subparagraph (A) of this paragraph is then divided by the total number of base year claims to derive the base SDA.
- (3) An urban hospital may receive increases to the base SDA for any of the following.
  - (A) Add-on amounts, which will be determined or adjusted based on the following.
    - (i) Impact files:
      - (I) HHSC will use the most recent finalized impact file available at the time of realignment to calculate add-ons; and
      - (II) HHSC will use the impact file in effect at the last realignment to calculate add-ons for new hospitals, except as otherwise specified in this section.
    - (ii) Geographic wage reclassification. If a hospital becomes eligible for the geographic wage reclassification under Medicare, the hospital will become eligible for the adjustment upon the next realignment.
    - (iii) Medical education add-on during fiscal year. If an existing hospital has a change in its medical education operating adjustment factor under Medicare, the hospital will become eligible for the adjustment to its medical education add-on upon the next realignment.
    - (iv) New medical education add-on. If a hospital becomes eligible for the medical education add-on after the most recent realignment:

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**HOSPITAL SERVICES (continued)**

- (I) the hospital will receive a medical education add-on, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year; and
  - (II) HHSC will calculate the add-on using the impact file in effect at the time the hospital initially claims eligibility for the medical education add-on; and
  - (III) this amount will remain fixed until the next realignment.
- (B) Geographic wage add-on;
- (i) Designated impact file. Subsequent add-ons will be based on the impact file available at the time of realignment.
  - (ii) Wage index. To determine an urban geographic wage add-on, HHSC first calculates a wage index for Texas as follows.
    - (I) HHSC identifies the Medicare wage index factor for each CBSA in Texas;
    - (II) HHSC identifies the lowest Medicare wage index factor in Texas;
    - (III) HHSC divides the Medicare wage index factor identified in subclause (I) of this clause for each CBSA by the lowest Medicare wage index factor identified in subclause (II) of this clause and subtracts one from each resulting quotient.
  - (iii) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification under the process described in subparagraph (F) of this paragraph.
  - (iv) Medicare labor-related percentage. HHSC uses the Medicare labor-related percentage available at the time of realignment.
  - (v) Geographic wage add-on calculation. The final geographic wage add-on is equal to the product of the base SDA calculated in subsection (d)(2)(B) of this section, the wage index calculated in clause (ii)(III) of this subparagraph, and the Medicare labor-related percentage in clause (iv) of this subparagraph.
- (C) Medical education add-on.
- (i) Eligibility. If an urban hospital meets the definition of a teaching hospital, as defined in subsection (b) of this section, it is eligible for the medical education add-on. Each hospital is required to confirm, under the process described in subparagraph (F) of this paragraph, that HHSC's determination of the hospital's eligibility and medical education operating adjustment factor under Medicare for the add-on is correct.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 15-0025

Effective Date: 09-01-21

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**HOSPITAL SERVICES (continued)**

(ii) Add-on amount. HHSC multiplies the base SDA calculated in subsection (d)(2)(B) of this section by the hospital's Medicare education adjustment factor to determine the hospital's medical education add-on amount.

(D) Trauma add-on.

(i) Eligibility.

(I) If an urban hospital meets the definition of a trauma hospital, as defined in subsection (b) of this section, it is eligible for a trauma add-on.

(II) HHSC initially uses the trauma level designation associated with the physical address of a hospital's TPI. A hospital may request that HHSC, under the process described in subparagraph (F) of this paragraph, use a higher trauma level designation associated with a physical address other than the hospital's TPI address.

(ii) Add-on amount. To determine the trauma add-on amount, HHSC multiplies the base SDA:

(I) by 28.3 percent for hospitals with Level 1 trauma designation;

(II) by 18.1 percent for hospitals with Level 2 trauma designation;

(III) by 3.1 percent for hospitals with Level 3 trauma designation; or

(IV) by 2.0 percent for hospitals with Level 4 trauma designation.

(iii) Reconciliation with other reimbursement for uncompensated trauma care. Subject to General Appropriations Act and other applicable law:

(I) if a hospital's allocation from the trauma facilities and emergency medical services account administered under Texas Health and Safety Code Chapter 780 is greater than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the Department of State Health Services will pay the hospital the difference between the two amounts at the time funds are disbursed from that account to eligible trauma hospitals; and

(II) if a hospital's allocation from the trauma facilities and emergency medical services account is less than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the hospital will not receive a payment from the trauma facilities and emergency medical services account.

(E) Safety-Net add-on

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 15-0025

Effective Date: 09-01-21

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**HOSPITAL SERVICES (continued)**

- (i) Eligibility. If an urban hospital meets the definition of a safety-net hospital as defined in subsection (b) of this section, they are eligible for a safety-net add-on.
  - (ii) Add-on amount. HHSC calculates the safety-net add-on amounts annually or at the time of realignment as follows.
    - (I) For each eligible hospital, determine the following amounts for a period of 12 contiguous months specified by HHSC:
      - (-a-) total allowable Medicaid inpatient days for fee-for-service claims;
      - (-b-) total allowable Medicaid inpatient days for managed care encounters;
      - (-c-) total relative weights for fee-for-service claims; and
      - (
    - (II) Determine the total allowable days for eligible safety-net hospitals by summing the amounts in items (-a-) and (-b-) of subclause (I) of this clause.
    - (III) Determine the hospital's percentage of total allowable days to the total in subclause (II) of this clause.
    - (IV) Determine the hospital's portion of appropriated safety-net funds before the MCO adjustment factor is applied by multiplying the amount in subclause (III) of this clause for each hospital by the total safety-net funds deflated to the data year.
    - (V) For each hospital, multiply item (-d-) of this subclause by the relevant MCO adjustment factor.
    - (VI) Sum the amounts in item (-c-) of subclause (I) of this clause and subclause (V) of this clause for each hospital.
    - (VII) To calculate the safety-net add-on, divide the amount in subclause (IV) of this clause by the amount in subclause (VI) of this clause for each hospital. The result is the safety-net add-on.
  - (iii) Reconciliation. Effective for costs and revenues accrued on or after September 1, 2015, HHSC may perform a reconciliation for each hospital that received the safety-net add-on to identify any such hospitals with total Medicaid reimbursements for inpatient and outpatient services in excess of their total Medicaid and uncompensated care inpatient and outpatient costs. For hospitals with total Medicaid reimbursements in excess of total Medicaid and uncompensated care costs, HHSC may recoup the difference.
- (F) Add-on status verification.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 19-0026

Effective Date: 09-01-21

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**HOSPITAL SERVICES (continued)**

- (i) Notification. HHSC will determine a hospital's initial add-on status by reference to the impact file available at the time of realignment or at the time of eligibility for a new medical education add-on as described in subparagraph (A)(iv) of this paragraph; the Texas Department of State Health Services' list of trauma-designated hospitals; and Medicaid days and relative weight information from HHSC's fiscal intermediary. HHSC will notify the hospital of the CBSA to which the hospital is assigned, the Medicare education adjustment factor assigned to the hospital for urban hospitals, the trauma level designation assigned to the hospital, and any other related information determined relevant by HHSC. For state fiscal years 2017 and after, HHSC will also notify eligible hospitals of the data used to calculate the safety-net add-on. HHSC may post the information on its website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, or provide the information to the hospital associations to disseminate to their member hospitals.
  
- (ii) During realignment, HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:
  - (I) the hospital provides documentation of its eligibility for a different medical education add-on or teaching hospital designation;
  - (II) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA;
  - (III) the hospital provides documentation of its eligibility for a different trauma designation; or
  - (IV) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.
  
- (iii) Annually, HHSC will calculate a hospital's final SDA using the add-on status initially determined during realignment by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital (in a format determined by HHSC) that any add-on status determined by HHSC is incorrect and:
  - (I) the hospital provides documentation of new teaching program or new teaching hospital designation; or
  - (II) the hospital provides documentation of its eligibility for a different trauma designation; or
  - (III) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 15-0025

Effective Date: 09-01-21

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### **HOSPITAL SERVICES (continued)**

- (iv) If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.
- (4) Urban hospital final SDA calculations. HHSC calculates an urban hospital's final SDA as follows.
- (A) Add all add-on amounts for which the hospital is eligible to the base SDA. These are the fully funded final SDAs.
  - (B) Multiply the final SDA determined in subparagraph (A) of this paragraph by each urban hospital's total relative weight of the base year claims.
  - (C) Sum the amount calculated in subparagraph (B) of this paragraph for all urban hospitals.
  - (D) Divide the total funds appropriated for reimbursing inpatient urban hospital services under this section by the amount determined in subparagraph (C) of this paragraph.
  - (E) To determine the budget-neutral final SDA:
    - (i) multiply the base SDA in paragraph (2) of this subsection by the percentage determined in subparagraph (D) of this paragraph;
    - (ii) multiply each of the add-ons described in paragraph (3)(B)-(E) by the percentage determined in subparagraph (D) of this paragraph; and
    - (iii) sum the results of clause (i) and (ii) of this subparagraph.
  - (F) For new urban hospitals for which HHSC has no base year claim data, the final SDA is a base SDA plus any add-ons for which the hospital is eligible, multiplied by the percentage determined in subparagraph (D) of this paragraph.
- (e) Rural hospital SDA calculations. HHSC will use the methodologies described in this subsection to determine the final SDA for each rural hospital.
- (1) HHSC calculates the rural final SDA as follows.
- (A) Base year cost. Calculate the total inpatient base year cost per rural hospital.
    - (i) Total the inpatient charges by hospital for the rural base year stays.
    - (ii) Multiply clause (i) by the inpatient RCC and the inflation update factors to inflate the base year claims to the current year of the realignment.

## **METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

### **HOSPITAL SERVICES (continued)**

- (B) Full-cost SDA. Calculate a hospital-specific full-cost SDA by dividing each hospital's base year cost, calculated as described in subparagraph (A) of this paragraph, by the sum of the relative weights for the rural base year stays.
- (C) Calculating the SDA floor and ceiling.
  - (i) Calculate the average adjusted hospital-specific SDA from subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.
  - (ii) Calculate the standard deviation of the hospital-specific SDAs identified in subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.
  - (iii) Calculate an SDA floor as clause (i) minus clause (ii) multiplied by a factor determined by HHSC to maintain budget neutrality.
  - (iv) Calculate an SDA ceiling as clause (i) plus clause (ii) multiplied by a factor determined by HHSC to maintain budget neutrality.
- (D) Assigning a final hospital-specific SDA.
  - (i) If the adjusted hospital-specific SDA from subparagraph (B) is less than the SDA floor in subparagraph (C)(iii) of this paragraph, the hospital is assigned the SDA floor amount as the final SDA.
  - (ii) If the adjusted hospital-specific SDA from subparagraph (B) is more than the SDA ceiling in subparagraph (C)(iv), the hospital is assigned the SDA ceiling amount as the final SDA.
  - (iii) Assign the adjusted hospital-specific SDA as the final SDA to each hospital not described in clauses (i) and (ii) of this subparagraph.
- (2) Alternate SDA for labor and delivery. For labor and delivery services provided by rural hospitals on or after September 1, 2019, the final SDA is the alternate SDA for labor and delivery stays, which is equal to the final SDA determined in paragraph (1)(D) of this subsection plus an SDA add-on sufficient to increase paid claims by no less than \$500.
- (3) HHSC calculates a new rural hospital's final SDA as follows.
  - (A) For new rural hospitals for which HHSC has no base year claim data, the final SDA is the mean rural SDA in paragraph (1)(C)(i) of this subsection.
  - (B) The mean rural SDA assigned in subparagraph (A) of this paragraph remains in effect until the next realignment.
- (4) Biennial review of rural rates. Every two years, HHSC will calculate new rural SDAs using the methodology in this subsection to the extent allowed by federal law and subject to limitations on appropriations.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 13-0036

Effective Date: 09-01-21

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### HOSPITAL SERVICES (continued)

- (f) Final SDA for military and out-of-state. The final SDA for military and out-of-state hospitals is the urban hospital base SDA multiplied by the percentage determined in subsection (d)(4)(D) of this section.
- (g) DRG statistical calculations. HHSC rebases the relative weights, MLOS and day outlier threshold whenever the base SDAs for urban hospitals are recalculated. The relative weights, MLOS, and day outlier thresholds are calculated using data from urban hospitals and apply to all hospitals. The relative weights that were implemented for urban hospitals on September 1, 2012, apply to all hospitals until the next realignment.
- (1) Recalibration of relative weights. HHSC calculates a relative weight for each DRG as follows.
- (A) Base year claims are grouped by DRG
  - (B) For each DRG, HHSC:
    - (i) sums the base year costs per DRG as determined in subsection (d) of this section;
    - (ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG; and
    - (iii) divides the result in clause (ii) of this subparagraph by the universal mean, resulting in the relative weight for the DRG.
- (2) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows.
- (A) Base year claims are grouped by DRG.
  - (B) For each DRG, HHSC:
    - (i) sums the number of days billed for all base year claims; and
    - (ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.
- (3) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows.
- (A) Calculate for all claims the standard deviations from the MLOS in paragraph (2) of this subsection.
  - (B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.
  - (C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.

## **METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

### **HOSPITAL SERVICES (continued)**

- (D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph.
  - (E) Calculate one standard deviation for the result in subparagraph (D) of this paragraph.
  - (F) Multiply the result in subparagraph (E) of this paragraph by two and add that to the result in subparagraph (D) of this paragraph, resulting in the day outlier threshold for the DRG.
- (4) If a DRG has fewer than five base year claims, HHSC will use National Claim Statistics and a scaling factor to assign a relative weight, MLOS, and day outlier threshold.
- (5) Adjust the MLOS, day outlier, and elbaite weights to increase or decrease with SOI to coincide with the National Claim Statistics.
- (h) DRG grouper logic changes. Beginning September 1, 2021, HHSC may adjust DRG statistical calculations to align with annual grouper logic changes. The changes will remain budget neutral unless rates are rebased, and additional funding is appropriated by the legislature. The adjusted relative weights, MLOS, and day outlier threshold apply to all hospitals until the next adjustment or rebasing described in subsection (g) of this section.
- (1) Base year claim data and rural base year stays are regrouped using the latest grouping software version to determine DRG assignment changes by comparing the newly assigned DRG to the DRG assignment from the previous grouper version.
  - (2) For DRGs impacted by the grouper logic changes, relative weights must be adjusted. HHSC calculates a relative weight for each impacted DRG as follows.
    - (A) Divide the total cost for all claims in the base year by the number of claims in the base year.
    - (B) Base year claims and rural base year stays are grouped by DRG, and for each DRG HHSC:
      - (i) sums the base year costs for all claims in each DRG;
      - (ii) divides the result in clause (i) of this subparagraph by the number of claims in each DRG; and
      - (iii) divides the result in clause (ii) of this subparagraph by the amount determined in subparagraph (A) of this paragraph, resulting in the relative weight for the DRG.
  - (3) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows.
    - (A) Base year claims and rural base year stays are grouped by DRG.
    - (B) For each DRG, HHSC:
      - (i) sums the number of days billed for all base year claims; and
      - (ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.

## **METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

### **HOSPITAL SERVICES (continued)**

- (4) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows.
  - (A) Calculate for all claims the standard deviations from the MLOS in paragraph (3) of this subsection.
  - (B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.
  - (C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.
  - (D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph.
  - (E) Calculate one standard deviation from the result in subparagraph (D) of this paragraph and multiply by two.
  - (F) Add the result of subparagraph (E) of this paragraph to the result in subparagraph (D) of this paragraph resulting in the day outlier threshold for the DRG.
- (5) If a DRG has fewer than five base year claims. HHSC will use National Claim Statistics and a scaling factor to assign a relative weight, MLOS, and day outlier threshold.
- (6) Adjust the MLOS, day outliers, and relative weights to increase or decrease with SOI to coincide with the National Claim Statistics.

#### **(i) Reimbursements**

- (1) Calculating the payment amount. HHSC reimburses a hospital a prospective payment for covered inpatient hospital services by multiplying the hospital's final SDA as calculated in subsection (c)-(f) of this section as applicable by the relative weight for the DRG assigned to the adjudicated claim. The resulting amount is the payment amount to the hospital.
- (2) The prospective payment as described in paragraph (1) of this subsection is considered full payment for covered inpatient hospital services. A hospital's request for payment in an amount higher than the prospective payment will be denied.
- (3) Day and cost outlier adjustments. HHSC pays a day outlier or a cost outlier for medically necessary inpatient services provided to clients under age 21 in all Medicaid participating hospitals that are reimbursed under the prospective payment system. If a patient age 20 is admitted to and remains in a hospital past his or her 21st birthday, inpatient days and hospital charges after the patient reaches age 21 are included in calculating the amount of any day outlier or cost outlier payment adjustment.
  - (A) Day outlier payment adjustment. HHSC calculates a day outlier payment adjustment for each claim as follows:
    - (i) Determine whether the number of medically necessary days allowed for a claim exceeds:

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 13-0036

Effective Date: 09-01-21

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**HOSPITAL SERVICES (continued)**

- (I) the MLOS by more than two days; and
  - (II) the DRG day outlier threshold as calculated in subsection (g)(3) of this section.
  - (ii) If clause (i) of this subparagraph is true, subtract the DRG day outlier threshold from the number of medically necessary days allowed for the claim
  - (iii) Multiply the DRG relative weight by the final SDA
  - (iv) Divide the result in clause (iii) of this subparagraph by the DRG MLOS described in subsection (g)(2) or (h)(3) of this section, to arrive at the DRG per diem amount
  - (v) Multiply the number of days in clause (ii) of this subparagraph by the result in clause (iv) of this subparagraph.
  - (vi) Multiply the result in clause (v) of this subparagraph by 60 percent.
  - (vii) Multiply the allowed charges by the current interim rate to determine the cost.
  - (viii) Subtract the DRG payment amount calculated in clause (iii) of this subparagraph from the cost calculated in clause (vii) of this subparagraph.
  - (ix) The day outlier amount is the lesser of the amount in clause (vi) of this subparagraph or the amount in clause (viii) of this subparagraph.
  - (x) For urban and rural hospitals, multiply the amount in clause (ix) of this subparagraph by 90 percent to determine the final day outlier amount. For children's hospitals the amount in clause (ix) of this subparagraph is the final day outlier amount.
- (B) Cost outlier payment adjustment. HHSC makes a cost outlier payment adjustment for an extraordinarily high-cost claim as follows:
- (i) To establish a cost outlier, the cost outlier threshold must be determined by first selecting the lesser of the universal mean of base year claims and rural base year stays multiplied by 11.14 or the hospital's final SDA multiplied by 11.14.
  - (ii) Multiply the full DRG prospective payment by 1.5.
  - (iii) The cost outlier threshold is the greater of clause (i) or (ii) of this subparagraph.
  - (iv) Subtract the cost outlier threshold from the amount of reimbursement for the claim established under cost reimbursement principles described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).
  - (v) Multiply the result in clause (iv) of this subparagraph by 60 percent to determine the amount of the cost outlier payment
  - (vi) For urban and rural hospitals, multiply the amount in clause (v) of this subparagraph by 90 percent to determine the final cost outlier amount. For

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 13-0036

Effective Date: 09-01-21

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**HOSPITAL SERVICES (continued)**

children's hospitals the amount in clause (v) of this subparagraph is the final cost outlier amount.

(C) Final outlier determination:

- (i) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero, HHSC pays the higher of the two amounts.
- (ii) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is less than or equal to zero, HHSC pays the day outlier amount.
- (iii) If the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero and the amount calculated in subparagraph (A)(ix) of this paragraph is less than or equal to zero, HHSC pays the cost outlier amount.
- (iv) If the amount calculated in subparagraph (A)(ix) of this paragraph and the amount calculated in subparagraph (B)(vi) of this paragraph are both less than or equal to zero HHSC will not pay an outlier for the admission.

(D) If the hospital claim resulted in a downgrade of the DRG related to reimbursement denials or reductions for preventable adverse events, the outlier payment will be determined by the lesser of the calculated outlier payment for the non-downgraded DRG or the downgraded DRG.

- (4) A hospital may submit a claim to HHSC before a patient is discharged, but only the first claim for that patient will be reimbursed the prospective payment described in paragraph (1) of this subsection. Subsequent claims for that stay are paid zero dollars. When the patient is discharged, and the hospital submits a final claim to ensure accurate calculation for potential outlier payments for clients younger than age 21, HHSC recoups the first prospective payment and issues a final payment in accordance with paragraphs (1) and (3) of this subsection.
- (5) Patient transfers and split billing. If a patient is transferred, HHSC establishes payment amounts as specified in subparagraphs (A) - (D) of this paragraph. HHSC manually reviews transfers for medical necessity and payment.

(A) If the patient is transferred from a hospital to a nursing facility, HHSC pays the transferring hospital the total payment amount of the patient's DRG.

(B) If the patient is transferred from one hospital (transferring hospital) to another hospital (discharging hospital), HHSC pays the discharging hospital the total payment amount of the patient's DRG. HHSC calculates a DRG per diem and a payment amount for the transferring hospital as follows.

- (i) Multiply the DRG relative weight by the final SDA
- (ii) Divide the result in clause (i) of this subparagraph by the DRG MLOS described in subsection (g)(2) or (h)(3) of this section, to arrive at the DRG per diem amount.
- (iii) To arrive at the transferring hospital's payment amount:

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 13-0036

Effective Date: 09-01-21

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- (I) for a patient age 21 or older, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS, the transferring hospital's number of medically necessary days allowed for the claim, or 30 days; or
  - (II) for a patient under age 21, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS or the transferring hospital's number of medically necessary days allowed for the claim.
- (C) HHSC makes payments to multiple hospitals transferring the same patient by applying the per diem formula in subparagraph (B) of this paragraph to all the transferring hospitals and the total DRG payment amount to the discharging hospital.
- (D) HHSC performs a post-payment review to determine if the hospital that provided the most significant amount of care received the total DRG payment. If the review reveals that the hospital that provided the most significant amount of care did not receive the total DRG payment, an adjustment is initiated to reverse the payment amounts. The transferring hospital is paid the total DRG payment amount and the discharging hospital is paid the DRG per diem.
- (j) Cost reports. Each hospital must submit an initial cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by HHSC.
- (1) Each hospital must send a copy of all cost reports audited and amended by a Medicare intermediary to HHSC within 30 days after the hospital's receipt of the cost report. Failure to submit copies or respond to inquiries on the status of the Medicare cost report will result in provider vendor hold.
  - (2) HHSC uses data from these reports when realigning or rebasing to calculate base SDAs, DRG statistics, and interim rates and to complete cost settlements.
- (k) Cost Settlement.
- (1) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) for children's and state-owned teaching hospitals.
  - (2) Notwithstanding the process described in paragraph (1) of this subsection, HHSC uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for a hospital.
  - (3) HHSC may select a new base year period for calculating the TEFRA target cap at least every three years.
  - (4) HHSC increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the hospital's target cap by the CMS Prospective Payment System Hospital Market Basket Index adjusted to the hospital's fiscal year.
  - (5) For a new children's hospital, the base year for calculating the TEFRA target cap is the hospital's first full 12-month cost reporting period occurring after the date the hospital is designated by Medicare as a children's hospital. For each cost reporting period after

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 11-0036

Effective Date: 09-01-21

## METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

### HOSPITAL SERVICES (continued)

the hospital's base year, an increase in the TEFRA target cap will be applied as described in paragraph (4) of this subsection, until the TEFRA target cap is recalculated as described in paragraph (3) of this subsection.

- (6) After a Medicaid participating hospital is designated by Medicare as a children's hospital, the hospital must submit written notification to HHSC's provider enrollment contact, including documents verifying its status as a Medicare children's hospital. Upon receipt of the written notification from the hospital, HHSC will convert the hospital to the reimbursement methodology described in this subsection retroactive to the effective date of designation by Medicare.

(l) Out-of-state children's hospitals. HHSC calculates the prospective payment rate for an out-of-state children's hospital as follows.

- (1) HHSC determines the overall average cost per discharge for all in-state children's hospitals by:
  - (A) summing the Medicaid allowed cost from tentative or final cost report settlements for the base year; and
  - (B) dividing the result in subparagraph (A) of this paragraph by the number of in-state children's hospitals' base year claims.
- (2) HHSC determines the average relative weight for all of in-state children's hospitals' base year claims by:
  - (A) assigning a relative weight to each claim pursuant to subsection (g)(1)(B)(iii) or (h)(2)(B)(ii) of this section;
  - (B) summing the relative weights for all claims; and
  - (C) dividing by the number of claims.

(m) Merged hospitals.

- (1) When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to HHSC's provider enrollment contact, including documents verifying the merger status with Medicare.
- (2) The merged entity receives the final SDA of the hospital associated with the surviving TPI. HHSC will reprocess all claims for the merged entity back to the effective date of the merger or the first day of the fiscal year, whichever is later.
- (3) HHSC will not recalculate the final SDA of a hospital acquired in an acquisition or buyout unless the acquisition or buyout resulted in the purchased or acquired hospital becoming part of another Medicaid participating provider. HHSC will continue to reimburse the acquired hospital based on the final SDA assigned before the acquisition or buyout.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 10-0041

Effective Date: 09-01-21

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**HOSPITAL SERVICES (continued)**

- (4) When Medicare requires a merged hospital to maintain two Medicare numbers because they are in different CBSAs, HHSC assigns one base TPI with a separate suffix for each facility. Both suffixes receive the SDA of the primary hospital ID which remains active.

(n) - (x) Intentionally left blank.

TN: 21-0032

Approval Date: April 12, 2022

Supersedes TN: 15-0025

Effective Date: 09-01-21