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

The Texas Health and Human Services Commission (HHSC) proposes the repeal of §355.8052, concerning Medicaid Inpatient Hospital Reimbursement; and proposes new §355.8052, concerning Medicaid Inpatient Hospital Reimbursement, in Chapter 355, Reimbursement Rates.

Background and Justification

HHSC proposes to repeal current §355.8052 and replace it with new §355.8052 describing the prospective payment system applicable to Medicaid inpatient hospital payments. The proposed methodology establishes a statewide base standard dollar amount (SDA) that is intended to address the effects of the current hospital-specific rate methodology, which can result in different payments to similarly situated hospitals for the same or similar services. Teaching hospitals and trauma-designated hospitals are eligible for increases to the statewide base SDA, in recognition of the high-cost functions of those groups of providers. Increases to the statewide base SDA are also available based on wage differences related to the geographic area in which each prospectively-paid inpatient hospital is located.

The proposed rule implements the requirements of the 2012-13 General Appropriations Act (Article II, Health and Human Services Commission, H.B. 1, Rider 67 and Rider 61(b)(17), 82nd Legislature, Regular Session, 2011), which direct HHSC to develop a statewide SDA and authorize HHSC to consider high-cost hospital functions and services, including regional differences. The proposed rule also reflects direction in Article II regarding inpatient hospital rates, including HHSC Rider 61(b)(29), related to appropriate payments to outlier hospitals, HHSC Rider 67, related to mitigation of disproportionate losses up to September 1, 2012, and Special Provisions, Section 16(b)(5), related to reducing hospital rates by eight percent. The proposed rule also reflects legislative direction in Article IX, General Provisions, Section 18.19, related to the use of trauma fund receipts for Medicaid reimbursement purposes.

Under the current methodology, which HHSC proposes to repeal, HHSC calculates a hospital-specific SDA for each prospectively-paid Medicaid inpatient hospital. The hospital-specific SDA is calculated based on each hospital's charges, converted to cost, for providing Medicaid services. Hospital-specific SDAs are grouped into payment divisions and assigned a payment division SDA, which is multiplied by relative weight for the diagnosis-related group (DRG) to determine the reimbursement amount. In recent years, this methodology has come under scrutiny as having the potential to reward inefficient and high-cost providers.

A statewide SDA, combined with appropriate adjustments for certain high-cost functions and services (called "add-ons" in the proposed rule), provides each hospital the incentive to manage its costs and, if the hospital desires, expand its services to include one or more of the high-cost services. For example, a hospital may choose to earn an increased SDA by obtaining a trauma

designation or achieving a higher-level trauma designation, or it may choose to become a teaching hospital or take steps to increase its Medicare education adjustment factor.

To facilitate the transition to a statewide SDA, the Texas Legislature authorized HHSC to use up to $20 million in general revenue funds during the first year that the statewide rate is in effect to mitigate the fiscal impact to hospitals that are disproportionately impacted by the proposed transition to a statewide rate. The proposed rule describes the methodology used to identify the disproportionately impacted hospitals and to mitigate the impact to that group of hospitals.

The Legislature also authorized the transfer of funds to HHSC from the Trauma Facilities and Emergency Medical Services account administered by the Department of State Health Services in order to support the establishment and maintenance of trauma and emergency care facilities across the state by maximizing the availability of federal funds to reimburse trauma hospitals. The proposed methodology assures that reimbursements to a hospital using those funds will not be less than the amount the hospital otherwise would have received for uncompensated trauma care from the Trauma Facilities and Emergency Medical Services account.

HHSC modified the calculation of day and cost outliers by reducing the reimbursement percentage from 70 percent to 60 percent.

The proposed rule also notes that HHSC may, consistent with other administrative rules, adjust rates to accommodate available appropriated funds. HHSC will adjust rates pursuant to this authority to account for the eight percent hospital rate reduction specified in the 2012-13 General Appropriations Act.

HHSC anticipates that the proposed rule will be in effect for inpatient hospital reimbursement only for state fiscal year 2012. HHSC anticipates promulgating a new rule for inpatient reimbursements beginning in state fiscal year 2013, following the next rebasing process and the transition to the all-patient refined diagnosis-related groups.

The methodology described in the proposed rule does not apply to children's hospitals, state-owned teaching hospitals, freestanding psychiatric hospitals, or hospitals in counties with 50,000 or fewer persons and certain other hospitals. The methodologies for reimbursing those hospitals are described in §§355.8054, 355.8056, and 355.8060 and in proposed §355.8055, which was published in the July 1, 2011, issue of the *Texas Register* (36 TexReg 4013).

Section-by-Section Summary

Current §355.8052 is repealed in its entirety. The provisions in current §355.8052(i) concerning rural and certain other hospitals are being relocated to proposed new §355.8055, which was published in the July 1, 2011, issue of the *Texas Register* (36 TexReg 4013).

Proposed new §355.8052(a) generally describes the reimbursement method and clarifies that the prospective payment system applies to inpatient hospital payments for fiscal year 2012 or until HHSC implements a new reimbursement methodology.

Proposed new §355.8052(b) lists the types of hospitals that are exceptions to the prospective payment system described in the proposed rule and identifies the rules describing reimbursement methodologies for those hospitals.

Proposed new §355.8052(c) defines the terms used in the proposed rule and in other inpatient hospital reimbursement rules.

Proposed new §355.8052(d) describes the methodology used to calculate a statewide base SDA.

Proposed new §355.8052(e) lists the categories of add-ons to the statewide base SDA that a hospital may be eligible to receive. This subsection also describes the eligibility criteria for each category of add-on and the methodology used to calculate the amount of the add-on. This subsection also describes the procedure HHSC used to verify each hospital's add-on status and the potential consequences to a hospital for failing to confirm the accuracy of its add-on status.

Proposed new §355.8052(f) describes the methodology used to calculate a hospital's final SDA, including that HHSC may adjust the final SDA based on available appropriations. This subsection includes a description of the methodology used to identify hospitals that are disproportionately impacted by the transition to a statewide SDA and to mitigate the impact to those hospitals in state fiscal year 2012. The subsection describes the final SDA that will be assigned to military and out-of-state hospitals, to merged hospitals, and to other hospitals for which HHSC has no base-year claim data.

Proposed new §355.8052(g) describes the methodology used to calculate relative weights for each diagnosis-related group; to recalibrate mean length of stay; and to recalibrate day outlier thresholds.

Proposed new §355.8052(h) describes the methodology used to calculate the payment amount for Medicaid services. This subsection also describes the methodology for calculating day and cost outlier adjustments. Additionally, HHSC modified the calculation of day and cost outlier adjustments by reducing the reimbursement percentage from 70 percent to 60 percent.

Proposed new §355.8052(i) describes the requirement that each hospital must submit cost reports at periodic intervals and provides that information from these reports is used in rebasing rate years to recalculate the base SDA.

Fiscal Note

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that, for the first five years the proposed repeal and new section are in effect, there are foreseeable implications relating to costs or revenues of state government.

The effect on state government for the first five years the proposed repeal and new section are in effect is an estimated reduction in cost of $219,176,376 all funds ($91,133,537 general revenue (GR)) in fiscal year (FY) 2012; $278,251,774 ($118,396,130 GR) in FY 2013; $289,677,812

($123,460,683 GR) in FY 2014; $301,573,045 ($128,530,432 GR) in FY 2015; and $313,956,740 ($133,808,363 GR) in FY 2016.

In addition to the fiscal impact above, the estimated additional funding available from the Trauma Facilities and Emergency Medical Services account administered by the Department of State Health Services (dedicated general revenue and the associated federal revenue) for each of the first five years is: $57,478,019 all funds ($23,899,360 dedicated general revenue (GRD)) in fiscal year (FY) 2012; $59,838,277 ($25,461,187 GRD) in FY 2013; $62,295,456 ($26,550,323 GRD) in FY 2014; $64,853,536 ($27,640,577 GRD) in FY 2015; and $67,516,660 ($28,775,600 GRD) in FY 2016.

Ms. Rymal anticipates that there will not be an economic cost to persons who are required to comply with the repeal and new section. There is no anticipated negative impact on local employment.

Ms. Rymal anticipates that there may be implications relating to costs or revenues of local government. The proposed new rule may have an adverse economic effect on revenues of local governments that own hospitals because reimbursement for all prospective inpatient hospital services is subject to the legislative budget reduction. The change in reimbursement methodology was implemented to limit the impact for disproportionately impacted hospitals, including those owned by local governments. Hospitals owned by local governments in counties with fewer than 50,000 residents are not reimbursed under this section and are not impacted by the proposed methodology.

Small Business and Micro-business Impact Analysis

Under §2006.002 of the Government Code, a state agency proposing an administrative rule that may have an adverse economic effect on small businesses must prepare an economic impact statement and, generally, a regulatory flexibility analysis. The economic impact statement estimates the number of small businesses subject to the rule and projects the economic impact of the rule on small businesses. The regulatory flexibility analysis describes the alternative methods the agency considered to achieve the purpose of the proposed rule while minimizing adverse effects on small businesses. A regulatory flexibility analysis is not required if the proposed rule is required by a state or federal mandate.

Carolyn Pratt, Director of Rate Analysis, has determined that the proposed repeal and new section may have an adverse economic effect on small businesses as a result of lower reimbursement for all prospectively paid inpatient hospital services due to legislative budget reduction. The change in reimbursement methodology was implemented to limit the impact for disproportionately impacted hospitals.

It is unknown the number of small or micro-businesses subject to the rule that may be impacted by the amendment.

As noted above, a methodology is proposed to mitigate the impact for disproportionately impacted hospitals. Alternative methods to achieve the purpose of the proposed rule are not required because the content of the rule is mandated by state law.

Public Benefit

Carolyn Pratt has also determined that, for each year of the first five years the repeal and new section are in effect, the anticipated public benefit expected as a result of enforcing the repeal and new section is that the previous disparity in payment to similarly-situated hospitals for providing the same service will be reduced or eliminated. Additionally, the public will benefit from the establishment of financial incentives, in the form of increases to the statewide base SDA, for hospitals to reduce costs and to expand their provision of one or more of the high-cost services.

Regulatory Analysis

HHSC has determined that this proposal is not a "major environmental rule" as defined by §2001.0225 of the Texas Government Code. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

Takings Impact Assessment

HHSC has determined that this 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 §2007.043 of the Texas Government Code.

Public Comment

Written comments on the proposal may be submitted to Chris Dockal, Rate Analysis, Health and Human Services Commission, P.O. Box 85200, MC-H400, Austin, Texas 78708-5200; by fax to (512) 491-1467; or by e-mail to chris.dockal@hhsc.state.tx.us, within 30 days after publication of this proposal in the *Texas Register.*

1 TAC §355.8052

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Health and Human Services Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

Statutory Authority

The repeal is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

The repeal affects the Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§355.8052.Inpatient Hospital Reimbursement.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102396

Steve Aragon

Chief Counsel

Texas Health and Human Services Commission

Earliest possible date of adoption: August 7, 2011

For further information, please call: (512) 424-6900

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1 TAC §355.8052

Statutory Authority

The new rule is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

The new rule affects the Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§355.8052.Inpatient Hospital Reimbursement.

(a) Application and general reimbursement method.

(1) The prospective payment system described in this section applies to inpatient hospital payments for state fiscal year 2012 or until the Health and Human Services Commission (HHSC) implements a new reimbursement methodology.

(2) HHSC calculates reimbursement for a covered inpatient hospital service, determined in subsection (h) of this section, by multiplying the hospital's final standard dollar amount (SDA), determined in subsection (f) of this section, by the relative weight for the appropriate diagnosis-related group, determined in subsection (g) of this section.

(b) Exceptions. The prospective payment system described in this section does not apply to the following types of hospitals for covered inpatient hospital services:

(1) In-state and out-of-state children's hospitals. In-state and out-of-state children's hospitals are reimbursed using the methodology described in §355.8054 of this division (relating to Children's Hospital Reimbursement Methodology).

(2) State-owned teaching hospitals. A state-owned teaching hospital is reimbursed in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) principles using the methodology described in §355.8056 of this division (relating to State-Owned Teaching Hospital Reimbursement Methodology).

(3) Freestanding psychiatric hospitals. A freestanding psychiatric hospital is reimbursed under the methodology described in §355.8060 of this division (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities).

(4) Hospitals in counties with 50,000 or fewer persons and certain other hospitals. A hospital in a county with 50,000 or fewer persons based on the 2000 decennial census and certain other hospitals are reimbursed under the methodology described in §355.8055 of this division (relating to Reimbursement Methodology for Rural and Certain Other Hospitals).

(c) Definitions. When used in this section, and §§355.8054 - 355.8056 of this division, the following words and terms have the following meanings, unless the context clearly indicates otherwise.

(1) Adjudicated--The approval or denial of an inpatient hospital claim by HHSC.

(2) Add-on--An amount that is added to the base SDA to reflect high-cost functions and services or regional cost differences.

(3) Base standard dollar amount (base SDA)--A standardized payment amount calculated by HHSC, as described in subsection (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 federal fiscal year 2008 (October 1, 2007 to September 30, 2008).

(5) Base year claims--All Medicaid traditional fee-for-service (FFS) and Primary Care Case Management (PCCM) inpatient hospital claims for reimbursement filed by 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, and hospitals described in subsection (b) of this section.

(6) Base year cost per claim--The cost for a base year claim that would have been paid to a hospital if HHSC reimbursed the hospital under methods and procedures used in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), without the application of the TEFRA target cap.

(7) Cost-of-Living Index--An adjustment applied to the base SDA and add-on amounts based on the Market Basket Index in effect in April 2009 to account for changes in cost of living.

(8) Cost outlier payment adjustment--A payment adjustment for a claim with extraordinarily high costs.

(9) Cost outlier threshold--One factor used in determining the cost outlier payment adjustment.

(10) Day outlier threshold--One factor used in determining the day outlier payment adjustment.

(11) Day outlier payment adjustment--A payment adjustment for a claim with an extended length of stay.

(12) Diagnosis-related group (DRG)--The classification of medical diagnoses as defined in the Medicare DRG system or as otherwise specified by HHSC.

(13) 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 in the case of children's hospitals, audited by HHSC.

(14) 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.

(15) Full-cost SDA--The sum of a hospital's base year costs per claim divided by the sum of the hospital's relative weights.

(16) 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.

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

(18) 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.

(19) 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).

(20) 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 a DRG hospital reimbursed under this section and §355.8055 of this division excludes the application of TEFRA target caps and the resulting incentive and penalty payments for a hospital's fiscal years ending on or after October 1, 2007.

(21) Market basket index--The Centers for Medicare and Medicaid Services (CMS) projection of the annual percentage increase in hospital inpatient operating costs.

(22) Mean length of stay (MLOS)--One factor used in determining the payment amount calculated for each DRG; for each DRG, the average number of days that a patient stays in the hospital.

(23) Medical education add-on--An adjustment to the base SDA for a teaching hospital to reflect higher patient care costs relative to non-teaching hospitals.

(24) Military hospital--A hospital operated by the armed forces of the United States.

(25) 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.

(26) Rebasing--Calculation of the base year cost per claim for each Medicaid inpatient hospital. For purposes of this section, HHSC is not rebasing.

(27) Relative weight--The weighting factor HHSC assigns to a DRG representing the time and resources associated with providing services for that DRG.

(28) State-owned teaching hospital--The following hospitals: University of Texas Medical Branch (UTMB); University of Texas Health Center Tyler; and M.D. Anderson Hospital.

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

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

(31) 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.

(32) Texas provider identifier--A unique number assigned to a provider of Medicaid services in Texas.

(33) 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.

(34) Trauma hospital--An inpatient hospital that meets the Texas Department of State Health Services criteria for a Level I, II, III, or IV trauma facility designation under 25 Texas Administrative Code §157.125 (relating to Requirements for Trauma Facility Designation).

(35) Universal mean--Average base year cost per claim for all hospitals.

(d) Base standard dollar amount (SDA) calculations. HHSC will use the methodologies described in this subsection to determine a statewide base SDA.

(1) HHSC calculates the universal mean as follows:

(A) Use the base year cost per claim for each hospital.

(B) Sum the dollar amount for all hospitals' base year costs per claim.

(C) Divide the result in subparagraph (B) of this paragraph by the total number of base year claims to derive the universal mean.

(2) From the amount determined in paragraph (1)(B) of this subsection, HHSC sets aside an amount to recognize high-cost hospital functions and services and regional wage differences. 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.

(A) The costs remaining after HHSC sets aside the amount for high-cost hospital functions and services will be used to determine the base SDA, as described in paragraphs (3) and (4) of this subsection.

(B) The costs HHSC sets aside will determine the funds available for distribution to hospitals that are eligible for one or more add-ons as described in subsection (e) of this section.

(3) HHSC divides the amount in paragraph (2)(A) of this subsection by the total number of base year claims.

(4) HHSC multiplies the amount calculated in paragraph (3) of this subsection by the cost-of-living index to derive the base SDA.

(e) Add-ons.

(1) A hospital may receive increases to the base SDA for any of the following:

(A) Geographic wage add-on, as described in paragraph (3) of this subsection.

(B) Medical education add-on, as described in paragraph (4) of this subsection.

(C) Trauma add-on, as described in paragraph (5) of this subsection.

(2) If a hospital becomes eligible for one or more add-ons during fiscal year 2012, the hospital will not receive an increased base SDA. A hospital may become eligible for add-on adjustments in subsequent fiscal years.

(3) Geographic wage add-on.

(A) Wage index. To determine a hospital's geographic wage add-on, HHSC first calculates a wage index for Texas as follows:

(i) HHSC identifies the Medicare wage index factor for each Core Based Statistical Area (CBSA) in Texas.

(ii) HHSC identifies the lowest Medicare wage index factor in Texas.

(iii) HHSC divides the Medicare wage index factor for each CBSA by the lowest Medicare wage index factor identified in clause (ii) of this subparagraph.

(iv) HHSC uses the result of the calculations in clause (iii) of this subparagraph to calculate each CBSA's add-on amount described in subparagraph (C) of this paragraph.

(B) 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 paragraph (6) of this subsection.

(C) Add-on amount.

(i) HHSC calculates 62 percent of the base SDA to derive the labor-related portion of that rate, consistent with the Medicare labor-related percentage.

(ii) To determine the geographic wage add-on amount for each CBSA, HHSC multiplies the wage index factor determined in subparagraph (A)(iv) of this paragraph for that CBSA by the percentage labor share of the base SDA calculated in clause (i) of this subparagraph.

(4) Medical Education add-on.

(A) Eligibility. A teaching hospital is eligible for the medical education add-on. Each hospital is required to confirm, under the process described in paragraph (6) of this subsection, that HHSC's determination of the hospital's eligibility and Medicare education adjustment factor for the add-on is correct.

(B) Add-on amount. HHSC multiplies the base SDA by the hospital's Medicare education adjustment factor to determine the hospital's medical education add-on amount.

(5) Trauma add-on.

(A) Eligibility.

(i) To be eligible for the trauma add-on, a hospital must be designated as a trauma hospital by the Texas Department of State Health Services and be eligible to receive an allocation from the trauma facilities and emergency medical services account under Chapter 780, Health and Safety Code.

(ii) HHSC initially uses the trauma level designation associated with the physical address of a hospital's Texas Provider Identifier (TPI). A hospital may request that HHSC, under the process described in paragraph (6) of this subsection, use a higher trauma level designation associated with a physical address other than the hospital's TPI address.

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

(i) by 12.8 percent for hospitals with Level 1 trauma designation;

(ii) by 8.2 percent for hospitals with Level 2 trauma designation;

(iii) by 1.4 percent for hospitals with Level 3 trauma designation; or

(iv) by 1.3 percent for hospitals with Level 4 trauma designation.

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

(i) If a hospital's allocation from the trauma facilities and emergency medical services account administered under Chapter 780, Health and Safety Code, 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 dispersed from that account to eligible trauma hospitals.

(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.

(6) Add-on status verification.

(A) Notification. HHSC will notify a hospital of its add-on status, as initially determined by HHSC, to identify the CBSA to which the hospital is assigned, the Medicare education adjustment factor assigned to the hospital, the trauma level designation assigned to the hospital, and any other related information determined relevant by HHSC. HHSC may post the information on HHSC's 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.

(B) 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 by regular mail, hand delivery or special mail delivery, 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 trauma designation or medical education percentage; or

(ii) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA.

(C) 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.

(f) Final SDA.

(1) HHSC calculates a hospital's final SDA as follows:

(A) Add all add-on amounts for which the hospital is eligible to the base SDA.

(B) Multiply the SDA determined in subparagraph (A) of this paragraph by the hospital's total relative weight of base year claims.

(C) Sum the amount calculated in subparagraph (B) of this paragraph for all hospitals.

(D) Divide the total funds appropriated for reimbursing inpatient hospital services under this section by the amount determined in subparagraph (C) of this paragraph.

(E) Multiply the SDA determined for each hospital in subparagraph (A) of this paragraph by the percentage determined in subparagraph (D) of this paragraph.

(2) A hospital is assigned the SDA derived in paragraph (1)(E) of this subsection as its final SDA, except that:

(A) such SDA will be reduced to the full-cost hospital SDA, if it exceeds the amount of the full-cost hospital SDA; or

(B) such SDA may be increased as described in paragraph (3) of this subsection.

(3) Adjustment to mitigate hospitals for disproportionate losses. A hospital may be eligible for an increase to the SDA determined in paragraph (1)(E) of this subsection based on the following methodology:

(A) HHSC identifies the SDA the hospital was assigned following the most recent rebasing and for which the hospital received notification and an opportunity to request review. Under §355.201 of this title (relating to Establishment and Adjustment of Reimbursement Rates by the Health and Human Services Commission), authorizing HHSC to adjust rates to stay within available appropriated funds, HHSC:

(i) multiplied such SDA by 62.32 percent;

(ii) multiplied the result of clause (i) of this subparagraph by the hospital's total relative weights used in the most recent rebasing;

(iii) divided the result of clause (ii) of this subparagraph by the hospital's total relative weights that were recalculated excluding the claims associated with hospitals described in subsection (b)(4) of this section;

(iv) multiplied the result of clause (iii) of this subparagraph by 98 percent;

(v) multiplied the result of clause (iv) of this subparagraph by 87 percent.

(B) HHSC compares the SDA calculated in paragraph (1)(E) of this subsection to the SDA calculated in subparagraph (A)(v) of this paragraph.

(i) If the SDA calculated in paragraph (1)(E) of this subsection is less than the SDA calculated in subparagraph (A)(v) of this paragraph, the hospital is assigned an SDA equal to the SDA calculated in subparagraph (A)(v) of this paragraph, proportionately reduced as necessary to stay within appropriated funds identified to mitigate disproportionate losses.

(ii) The SDA calculated in clause (i) of this subparagraph will be reduced to the highest individual hospital SDA computed in subsection (e) of this section, if it exceeds that amount.

(4) For military and out-of-state hospitals, the final SDA is the base SDA multiplied by the percentage determined in paragraph (1)(D) of this subsection.

(5) For hospitals other than those identified in paragraph (4) of this subsection for which HHSC has no base year claim data, the final SDA is the base SDA plus any add-ons for which the hospital is eligible, multiplied by the percentage determined in paragraph (1)(D) of this subsection.

(6) Merged hospitals.

(A) 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.

(B) When each of the merging hospitals was reimbursed under this section before the merger, HHSC will assign to the merged entity the final SDA assigned to the hospital associated with the surviving Texas Provider Identifier and will reprocess all claims for the merged entity back to the date of the merger.

(C) When one or more of the merging hospitals was not reimbursed under this section before the merger, the surviving TPI will determine whether the merged entity will be reimbursed under this section or under a methodology described elsewhere in this division.

(D) 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.

(7) Adjustments. HHSC may adjust a hospital's final SDA in accordance with §355.201 of this title.

(g) Diagnosis-related groups (DRGs) statistical calculations. HHSC adopts the classification of diagnoses defined in the Medicare DRG prospective payment system unless a revision is required based on Texas claims data or other factors, as determined by HHSC. HHSC recalibrates the relative weights, mean length of stay (MLOS), and day outlier threshold whenever the base SDAs are recalculated.

(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 claim 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;

(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.

(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 ten base year claims, HHSC will assign the corresponding Medicare relative weight and Medicare MLOS and will calculate the day outlier threshold based on the Medicare MLOS and standard deviation.

(5) If one of the DRGs specific to an organ transplant has fewer than five base year claims, HHSC will assign the corresponding Medicare relative weight and Medicare MLOS and will calculate the day outlier threshold based on the Medicare MLOS and standard deviation. In addition, HHSC adds a relative weight to account for the cost of procuring the organ to the Medicare relative weight for the DRG. HHSC uses the organ procurement costs published by the Acquisition of Organ Procurement Organization (AOPO). To calculate the relative weight for procurement, HHSC divides the average cost of organ procurement by the universal mean for all claims.

(h) 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 (f) of this section 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:

(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) 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.

(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 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.

(C) If an admission qualifies for both a day outlier and a cost outlier payment adjustment, HHSC pays the higher outlier payment.

(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) of this section, to arrive at the DRG per diem amount.

(iii) To arrive at the transferring hospital's payment amount:

(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.

(i) 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 in rebasing rate years to recalculate base SDAs and to complete cost settlements for children's hospitals, rural and certain other hospitals, and state-owned teaching hospitals as outlined in §§355.8054 - 355.8056 of this division.

(3) HHSC may require a hospital to provide additional data in a format and at a time specified by HHSC.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Texas Health and Human Services Commission

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For further information, please call: (512) 424-6900