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

ADOPTION PREAMBLE

The Texas Health and Human Services Commission (HHSC) adopts amendments to §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology, §355.8066, concerning Hospital-Specific Limit Methodology, and §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care.

Sections 355.8065, 355.8066, and 355.8212 are adopted with changes to the proposed text as published in the April 14, 2023, issue of the *Texas Register* (48 TexReg 1903). These rules will be republished.

BACKGROUND AND JUSTIFICATION

HHSC has operated portions of the Medicaid program under the authority of an 1115 Healthcare Transformation and Quality Improvement Demonstration Waiver (1115 Waiver) since 2011. When the 1115 Waiver began, Texas received authority for Medicaid-managed care for several populations of existing Medicaid beneficiaries as well as expenditure authority for two supplemental funding pools – the Delivery System Reform Incentive Payment (DSRIP) Program and the Uncompensated Care (UC) Program. The non-federal share of the payments was funded using primarily local funds matched with federal Medicaid funds. Payments were valued based on allocations that were made early in the waiver development process and were based upon projects, and then achievement, not the utilization of Medicaid services. When the waiver was renewed in 2017, the Special Terms and Conditions of the 1115 Waiver required Texas to reduce expenditures through DSRIP before ultimately ending the DSRIP program on September 30, 2021.

HHSC planned successor financial programs that were referred to collectively as the "DSRIP Transition." Through these successor financial programs, HHSC was able to fully replace (and exceed) the total Medicaid expenditures that would have been lost due to the end of DSRIP. This overall maintenance of funding in the health care system is important because the overall economic stability of Texas is not projected to be negatively impacted by the DSRIP Transition. However, complicating the DSRIP Transition, the COVID-19 global pandemic overlapped with the time frame and caused provider market instability and fundamental shifts in historically stable utilization. As a result of various limitations on expenditures and reimbursements contained within various federal statutes and regulations, HHSC was unable to replace expenditures on a per-provider or even a per-class basis, and the regional impact of the transition has resulted in disparate impacts in rural and urban markets.

DSRIP's endurance as a payment mechanism in the health care system in Texas for 10 years resulted in a reliance on those funds for many participating providers to not just incentivize performance, but to finance their underlying infrastructure and cover costs. For hospitals, DSRIP was one of several funding streams that providers relied on, and the transition from DSRIP to successor programs resulted in significant shifts among providers. For some rural hospitals and large urban public hospitals, their current payment projections for fiscal year 2022 and after are not equivalent to their payment levels under DSRIP. This difference is largely a result of all successor programs being based in some manner on Medicaid beneficiary utilization, rather than an allocation basis.

HHSC's approach to the DSRIP Transition was to create programs that were related to the delivery of Medicaid services. Given that Medicaid managed care is the Medicaid model through which the majority of services are delivered, HHSC focused efforts on the modification or creation of directed payment programs (DPPs) that would enable HHSC to increase payments to providers up to their average commercial reimbursement.

Understanding that programs and payments are interlinked due to the successive nature of how uncompensated costs are calculated, HHSC intended to move successively through each program in the payment flow to determine whether modifications or the creation of new programs were appropriate to support the DSRIP Transition. However, due to significant delays in the approval of the DPPs planned for the DSRIP Transition, these efforts were largely paused until a time when HHSC would have more certainty about the landscape of approved payments. Following the approval of the Comprehensive Hospital Increase Reimbursement Program (CHIRP), the Texas Incentives for Physicians and Professional Services (TIPPS), and the Rural Access for Primary and Preventive Services (RAPPS) in March 2022, HHSC began focusing efforts quickly on getting the programs implemented and reinvigorating efforts to examine the other programs. HHSC pursued a Medicaid state plan amendment (SPA) to create a new fee-for-service program, the Hospital Augmented Reimbursement Program, to act as a mechanism to increase reimbursements for public hospitals. Centers for Medicare & Medicaid Services (CMS) approved the SPA for public hospitals on August 31, 2022.

Now that the Medicaid payments for services delivered to Medicaid beneficiaries have been established, HHSC is moving in succession to examine modifications that may be necessary to the Disproportionate Share Hospital (DSH) program, as well as UC. Both of these programs incorporate payment limits in the allocation of the program pools, which HHSC has termed the State Payment Cap for the interim calculation and the Hospital-Specific Limit, a federally determined cap for audit and reconciliation.

HHSC had many requests from stakeholders related to potential modifications for DSH or UC and HHSC examined these programs in their entirety with the intent of ensuring that the funds are allocated in accordance with their purpose, where the funds were most likely to benefit a large number of Texans receiving care, and in

accordance with established state policy goals. HHSC examined each amended change against the framework of the following goals:

-no financial harm to state entities;
-maintain or increase payments to Rural Hospitals, if possible;
-limit the potential for recoupments of funds at the time of audit or reconciliation;
-ensure compliance with federal laws and regulations and state laws;
-sustainability of program structures, if federal reductions to DSH are ever implemented;
-increase clarity of the regulations;
-increase transparency of the existing administrative practices; and
-sustain long term stability in the financing of the programs.

To the greatest extent possible, HHSC believes the amended modifications to the rules adhere to those goals, while also ensuring that as many hospitals as possible receive sufficient payments to achieve financial stability and continue providing services to Medicaid clients and uninsured Texans.

State Payment Cap

From 1993 to 2012, Section 1923 (g)(1)(A) of the Social Security Act (SSA) limited a hospital's payments to no more than "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under [the Medicaid Act], other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year." This definition describes the federal Hospital Specific Limit (HSL), the maximum amount a hospital can be reimbursed for the cost of services provided to Medicaid and uninsured patients. It is the sum of the Medicaid shortfall and the hospital's unreimbursed costs of services to the uninsured. The HSL limits payments to hospitals in DSH and UC at the time of the audit or reconciliation, respectively. A higher HSL means a higher potential payment from one or both of those programs. Both programs have a set amount of funds that may be distributed in a program year.

Consequently, a hospital's DSH and UC payment was also dependent (to a certain extent) on the size of its HSL relative to the HSLs of other hospitals in those programs. Section 1923(g) of the SSA has limited DSH payments to the HSL since 1993. The uninsured component of the calculation has not changed. Until 2010, HHSC calculated the Medicaid shortfall component using Medicaid claim and payment data submitted to Texas Medicaid and Healthcare Partnership (TMHP). Only costs associated with submitted claims were included; only Medicaid payments offset those costs. However, CMS issued guidance in the form of answers to Frequently Asked Questions (FAQs) in January 2010 that interpreted Section 1923(g) to require that private insurance payments and Medicare payments offset costs in the HSL calculation. CMS' response to FAQ 33 instructed that all costs and payments associated with Medicaid-eligible patients, who were also covered by private insurance, must be included in the HSL calculation. This guidance primarily

impacted children's hospitals because they serve many children who are presumptively eligible for Medicaid based on low birth weight or catastrophic illnesses, without regard to family income or insurance coverage. As a result, many low-weight babies and children with disabilities may have family coverage even if they are also eligible for Medicaid. If the insurer pays for care at rates higher than the reported Medicaid cost, the insurance payment then acts to offset the uninsured or Medicaid shortfall costs of other patients.

FAQ 34 instructed that costs and payments for patients dually eligible for Medicare and Medicaid must be included. This guidance primarily impacted hospitals with high Medicare populations – i.e., those that serve a lot of dual-eligible patients. In response to CMS' guidance, HHSC revised the data it collected from hospitals to calculate the HSL for interim payments and the DSH audit. Starting in 2011, HHSC reduced hospitals' costs for the DSH program by their total private insurance and Medicare payment amounts, thus lowering their DSH or UC payments. This method of calculating costs is frequently referred to as a "full-offset" methodology.

In December 2014, Texas Children's Hospital (TCH) filed suit against CMS in federal district court in the District of Columbia (D.C.) challenging FAQ 33. TCH successfully obtained a temporary injunction. CMS was enjoined from enforcing, applying, or implementing FAQ 33 and from taking any action to recoup federal DSH funds based on a state's noncompliance with the policy. The definition at issue was one in which costs for Medicaid-secondary clients would be included, but any payments from third-party payors would not. This method is frequently referred to as a "no offset" methodology. In August 2016, CMS proposed a rule requiring that Medicare and other third-party insurance payments be considered when determining costs for calculating the HSL for DSH program payments. The rule codified CMS' interpretation of Section 1923(g) as articulated in FAQs 33 and 34 and CMS' arguments in various courts. The rule was to become effective June 2, 2017.

In addition to the TCH lawsuit, numerous lawsuits were filed in federal district courts challenging FAQs 33 and 34 and CMS' final rule. Courts issued preliminary injunctions against CMS in some cases and permanent injunctions when the cases were decided on the merits. On February 21, 2018, Doctors Hospital of Renaissance filed suit against CMS in the United States District Court for D.C. challenging FAQ 34 and the final rule. In May 2017, The Children's Hospital Association of Texas (CHAT) and four free-standing children's hospitals located in Minnesota, Virginia, and Washington filed suit in the United States District Court for D.C. alleging that CMS' final rule was contrary to the Medicaid Act. On March 2, 2018, the court ruled in favor of the plaintiffs and vacated the rule. On March 6, 2018, the court issued its memorandum opinion explaining the decision. The court determined that Section 1923(g), on its face, does not authorize including Medicare payments and private payments in the DSH limit calculation. The court vacated the rule and applied the decision to CMS nationwide; not just to plaintiffs.

On November 4, 2019, the 8th Circuit Court of Appeals ruled in favor of CMS and its final rule implementing FAQs 33 and 34. The decision was consistent with the August 2019 holding by the D.C. Circuit Court of Appeals that ruled against CHAT

and reversed the decision of the United State District Court for the District of Columbia. The final rule's effective date was retroactive, to June 2, 2017.

On December 27, 2020, the Consolidated Appropriations Act for 2021 was signed into law. Included within the legislation was a federal statutory change to remove the cost and payments of individuals with Medicare or third-party coverage from the definition and calculation of the HSL. This definition is commonly referred to as the "MACPAC" definition.

However, in Texas, two payment caps exist for hospitals that participate in DSH and UC. The HSL and the state payment cap (SPC), previously known as the interim HSL, that HHSC may define. The SPC is calculated in the payment year for DSH and UC but the federal payment cap is calculated two years after the payment year using updated data. HHSC had previously linked the interim HSL to the final HSL so there would be a limited chance that recoupment would occur after the final HSL was calculated. Due to the ongoing changes to the HSL, HHSC implemented an SPC that is wholly defined by the state and utilizes the full-offset methodology.

At the time that HHSC chose to define the SPC using the full-offset methodology, the HSL was similarly defined as using a full-offset methodology. Beginning in 2021 when the federal HSL definition moved to largely reflect the "MACPAC" methodology (described above), the two definitions diverged. Subsequently, HHSC has seen a large number of recoupments at the time of the audit or reconciliation of DSH or UC due to this divergence. These recoupments have most significantly impacted rural and state-owned institutions. As a result, maintaining the SPC definition as currently defined would be contrary to HHSC's stated goals for this project.

HHSC is modifying the SPC to become a dual-calculation limitation. This new definition of SPC would be the lesser of two payment ceilings. The first payment ceiling will be the Full-Offset Payment Ceiling. This payment ceiling will use the full-offset methodology to identify costs related to Medicaid and uninsured individuals where there are no revenues associated with any Medicaid or uninsured individuals available to pay for those expenditures. The second payment ceiling will be the Recoupment Prevention Payment Ceiling. This payment ceiling will use the federal HSL calculation to identify costs that are able to be reimbursed, but without inclusion of costs or payments that would not be considered during the audit or reconciliation. From this two-pronged approach to establishing the payment cap, HHSC will meet the goals established above of limiting the potential for recoupments, while also balancing the importance of financial stability for hospitals serving large portions of Medicaid clients or uninsured persons.

HHSC received comments regarding some language that providers felt required additional specificity. HHSC also received comments related to certain determinations that will be made by CMS. HHSC is adopting the proposed changes to the SPC rules with amendments in response to these comments with an immediate effective date.

Disproportionate Share Hospital Program

DSH payments are authorized by federal law to provide hospitals that serve a large share of Medicaid and low-income patients with additional funding. DSH payments are supplemental payments to help cover more of the cost of care for Medicaid and low-income patients. These payments cannot exceed a hospital's uncompensated costs for both Medicaid-enrolled and uninsured patients. DSH payments are the only Medicaid payment in federal law that is explicitly for paying the unpaid costs of care for uninsured patients. It can be used by states to offset or make up for low Medicaid base payments. However, it is affected by Medicaid base payments and other supplemental funding. For example, an increase to a hospital's base Medicaid payment and its other non-DSH supplemental funding may decrease a hospital's Medicaid shortfall, resulting in a reduction in its uncompensated care costs for which DSH pays.

DSH program payments are made by HHSC to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals. Federal law also limits FFP for DSH payments through the hospital-specific DSH limit. In Texas, the state has established a State Payment Cap that limits the amount of payments that a provider receives through the interim payment process. This adoption amends the calculation of the State Payment Cap effective for fiscal year 2023.

Effective for fiscal year 2024, the adoption also amends the definition of the rural provider classes, establishes a new rural DSH pool, describes a methodology for redistribution of certain recouped funds, modifies the calculation of the Low-Income Utilization Rate to reflect federal law, updates the payment allocation methodology, establishes changes to qualifications of the program, revises the advance payment methodology for federal fiscal year 2024, and makes other clarifying amendments. HHSC has decided to delay implementation of the rule changes in §355.6065 to fiscal year 2024 in response to concerns that providers had not budgeted for potential recoupments that might occur from their interim/advance payments as a result of the methodological changes.

HHSC will modify the advance payment methodology for DSH 2024 to pay providers based upon the estimated amount that they will receive in the 2024 final DSH payment in an effort to help providers avoid reliance on interim or advance payments that are inconsistent with the final payment methodology. Multiple commenters were concerned about recoupment of 2023 advance DSH payments due to the alteration of the DSH methodology and the mismatch of the advance payment methodology and the final payment methodology, and this issue will be perpetuated if the advance payment methodology does not align with the rule changes.

This rule amendment will establish an allocation methodology that is separate from the SPC to allocate Pool 2. This payment will consist of two sub-pools: Pool 2a and Pool 2b.

Pool 2a, the Standard DSH pool, was created in response to comments received that were concerned that providers that qualified for DSH might not receive a payment, that DSH is the program of last resort for Medicaid costs, and that teaching hospitals need financial support to continue their residency programs. To address these concerns Pool 2a pays every hospital the maximum of a standard payment amount or their Medicaid shortfall (based on the minimum of the full offset and MACPAC Medicaid shortfall). Two standard payment amounts will be used: an amount for hospitals with residents (to support the existence of residency programs across the state), and an amount for hospitals that do not have residents. The payment will be capped at their minimum SPC after considering the non-federal share associated with Pool 2a for all hospitals other than the transferring hospitals' portion of non-federal share transferred on behalf of private hospitals. The Standard DSH payment ensures that remaining uncovered Medicaid costs are reimbursed first and creates a predictable standard payment amount. This pool will protect smaller hospitals by allocating them a simple, predictable payment amount.

Pool 2b will consider hospitals' payment to cost ratio against the set percentage. Hospitals will receive payment based on a set percentage of their total costs after consideration of payments, including Pool 2a All Funds payments excluding the amount of IGT transferring hospitals transfer for private hospitals. DSH is the only Medicaid reimbursement option that remains to reimburse for any uncompensated Medicaid costs or non-charity uncompensated care. As such, providers who have high levels of non-Medicaid utilization, which is common among rural and large public providers, may benefit from a method that considers the unique opportunity for reimbursement available under DSH. Additionally, a reimbursement methodology that considers the proportion of total costs covered could help providers achieve more similar percentages of total costs reimbursed.

The low-income utilization rate (LIUR) is a ratio that represents the hospital's volume of inpatient charity care relative to total inpatient services. As currently defined, several providers have a LIUR over one hundred percent, and the rule is being amended to address this. The rule is also being amended to align state LIUR definition with the federal definition and to specify the use of LIUR for qualification purposes only.

The current rule provides that HHSC can redistribute recouped funds to eligible providers but does not describe the method of the calculation. This rule amendment will provide details of the redistribution methodology and describes two methods of calculation. The first method was formerly used in DSH years 2011-2017 and will continue to be implemented for DSH year 2020 and after and would redistribute funds proportionately to remaining Hospital Specific Limit (HSL) room for eligible hospitals. The rule amendment will also describe a second method used during DSH years 2018-2019 where recouped funds from non-state providers were redistributed to eligible providers using a weighted allocation methodology.

HHSC is incorporating this methodology for calculating payment redistributions to increase transparency regarding the existing practice.

HHSC is removing Children's Hospitals as a deemed ownership type to align with the federal rule which only provides exemption from the Two-Physician requirement in the conditions of participation. With this rule amendment, Children's Hospitals will be required to meet all eligibility criteria, continue to meet at least one qualification criteria and meet all the conditions of participation.

This rule amendment will also create a new condition of participation. Beginning in DSH program year 2024, providers, with the exception of rural hospitals, will be required to participate in all voluntary Medicaid programs that they are eligible for (e.g., CHIRP, public HARP, GME) in order to participate in DSH. This change will provide safeguard for the state share funding mechanism of the program and as a result ensure the stability of the DSH program.

The recommendation from the 2021 DSH workgroups to add level one trauma hospitals as a category of hospitals that Texas will deem for DSH qualification is not being pursued currently, although providers are welcome to provide public comment on the topic.

This amended rule will update the DSH rural definition to match the Hospital Inpatient Reimbursement rule §355.8052 and establish a new rural DSH pool. This change is intended to provide increased clarity regarding what hospitals are considered rural in the Medicaid program. Within the DSH program allocations, there is an opportunity for certain public hospitals to receive payments through "Pass 3." Pass 3 was intended to allow certain public hospitals an additional opportunity to receive DSH funding for which there was not another source of non-federal share funding available. However, a lack of non-federal share funds has not occurred in recent years, but HHSC has understood that rural hospitals in particular had come to rely on Pass 3 for DSH funding. Therefore, HHSC has been setting aside funds for Pass 3 for several years for this express purpose.

To more transparently and clearly achieve this purpose, HHSC is proposing the creation of a rural DSH sub-pool for hospitals that meet the same definition of rural in the inpatient reimbursement are categorized. The amount of the sub-pool will be equivalent to the amount that has been reserved for Pass 3 in recent years. If rural public hospitals cannot fully utilize the allocated funds, a percentage of any remaining funds will be made available to the rural private hospitals with any other funds being redirected back to the Pool 1 and Pool 2 secondary allocation.

The definition for inflation update factor was previously erroneously removed and will be added back to the DSH rule with this amendment. The definition for ratio of cost-to-charges has been updated to include inpatient and outpatient data. HHSC has added a definition for Tax Revenue which has not been historically defined. The term Total state and local payments has been updated to Total state and local subsidies and now includes inpatient and outpatient care to match the federal DSH rule.

Some institution for mental diseases providers have raised a concern about in lieu of services where an MCO pays for services delivered to clients in the 21-64 age

range but the costs and payments for these services are not currently included in DSH. HHSC is not amending the rule related to this topic but is interested in receiving comments on this issue.

Uncompensated Care Program

UC payments to hospitals are authorized under Section 1115 demonstrations. UC payments originated as a way for Texas to continue to expand managed care in Medicaid programs and continue making supplemental payments to hospitals. States negotiate the parameters of their UC pools with CMS. Texas UC payments may be used to reduce the actual uncompensated cost of medical services provided to uninsured individuals who meet a provider's charity care policy. The medical services must meet the definition of "medical assistance" as defined in federal law.

Under the terms of the January 15, 2021 1115 Waiver, HHSC negotiated for the continuation and resizing of the UC pool. The result of the first pool resizing is an increase in the pool by approximately $600 million annually, for a total of $4.5 billion for demonstration years 12 through 16. This expenditure authority may be utilized only for providers that are authorized to participate in UC who demonstrate charity care expenses. HHSC is adopting a methodology that the new, additional UC funding be considered for a different allocation methodology than the previously extant $3.9 billion. HHSC is defining this sub-pool as the High Impecunious Charge Hospital (HICH pool). HHSC had proposed that eligibility to receive funds from this pool would be restricted to rural hospitals, state-owned hospitals, and hospitals that have at least 30 percent of their charges from serving uninsured persons.

HHSC received several comments that requested that HHSC add specific hospital classes to be included in the HICH pool. HHSC will not make changes to add additional hospital classes, but recognizes that the 30 percent charge threshold that had been proposed might be too restrictive. Therefore, upon adoption, HHSC will amend the rule to lower the threshold of charges to 27.5 percent. HHSC will use 27.5 percent of charges as this threshold because it continues to represent a small number of hospitals – indicating that 27.5 percent is truly rare and a high portion of charges. This will target these funds to hospitals that serve a large volume of uninsured persons as part of their patient-mix as well as rural hospitals and state-owned facilities, consistent with HHSC's established goals.

In addition, the amended update removes the Regional Health Partnership (RHP) eligibility requirement that is no longer in effect as the RHP is no longer in operation with the discontinuation of DSRIP.

Clarifying Amendments

Throughout all three rules, HHSC has attempted, when possible, to align definitions, remove references to DSRIP or DSRIP-related requirements, and make other changes for clarity and ease of reading.

COMMENTS

The 31-day comment period ended May 15, 2023.

During this period, HHSC received comments regarding the proposed rules from 55 organizations and one individual, including Texas Organization of Rural and Community Hospitals (TORCH); Texas Association of Behavioral Health Systems (TBHS); Sun Behavioral Health; Summit Behavioral Healthcare; Texas Essential Healthcare Partnership; Baylor Scott and White Health; Children's Hospital Association of Texas; Preferred Management; Texas Essential Healthcare Partnership; Mission Regional Medical Center and Knapp Medical Center; DHR Health; Christus Health; Huntsville Memorial Hospital; JPS Health Network; Teaching Hospitals of Texas (THOT); Parkland Health; UMC Health System; University Health; University Medical Center El Paso; Harris Health Systems; South Texas Delegation; UTHealth East Texas; BSA Health System; Seton Medical Center Harker Heights; Baptist Hospital of Southeast Texas; Oakbend Medical Center; Big Bend Regional Medical Center; Unidos Contra La Diabetes; Hope Family Health Center; Regional Vice President; Tenet Health; Su Clinica; Memorial Hermann ; HCA Healthcare; Texas Health Resources; Texas Children's Financial Services; UT Health East Texas; Medical Center of Southeast Texas (MCSET); Texas Association of Voluntary Hospitals (TAVH); Medical Center Health Systems; Tenet Healthcare Corporation; Signature Healthcare Services; Universal Health Services (UHS); Nuestra Clinica Del Valle, INC; Seton Medical Center Harker Heights; Texas Hospital association; Oceans Healthcare; St. Luke’s Health and its hospitals; Lifepoint Health; Odessa Regional Medical Center; Community health Systems; Acadia Healthcare; Texas Scottish Rite Hospital for Children.

A summary of comments relating to the rules §355.8065, §355.8066, and §355.8212, and HHSC’s responses follows.

Regarding §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology:

Allocation Methodology.

Comment: Multiple commenters provided comments in support of the proposed allocation methodology. They stated that the proposed amendments are a comprehensive and transparent approach to consider all Medicaid payment programs and the costs of caring for those covered by Medicaid and those without insurance. They expressed support for the comprehensive approach of the proposed amendments as a measure to compare Medicaid payments made to different provider groups and as a way to achieve better equity between provider groups.

Response: HHSC appreciates the support. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters provided comments opposed to the proposed allocation methodology. They stated that moving to a cost-based methodology

disadvantages certain hospital classes and regions of the state because under the proposed rules some providers that qualify for DSH will not receive any payment, in particular private IMD hospitals and hospitals in the South Texas border region.

Response: HHSC disagrees that the proposed rules would have disadvantaged certain hospital classes or regions of the state as the changes proposed did not specifically exclude any geographic area or hospital class from receiving payment. HHSC does agree that the determination that a hospital is qualified and eligible for DSH indicates that a hospital should receive some payment from DSH, if the hospital has room under their state payment cap. Therefore, as a result of these comments, HHSC will amend the rules upon adoption to incorporate an updated allocation methodology to include a new standard DSH payment before the payment-to-cost pool. This addresses the commenters' concerns ensuring that providers that qualify for DSH from all hospital classes and geographic regions receive a payment. HHSC updated 355.8065(g) and 355.8065(h) to describe the methodology and updated 355.8065(b)(24) to ensure the appropriate cross-reference.

Comment: Multiple commenters provided comments opposed to the proposed allocation methodology stating that the methodology incentivizes increasing costs to increase payments and does not incentivize hospitals to serve Medicaid and uninsured patients.

Response: HHSC disagrees with the comment that moving to a payment-to-cost-based methodology would incentivize hospitals to inflate costs to increase payments because a provider is unlikely to receive full cost reimbursement through DSH and is therefore unlikely to inflate costs in order to receive a fractional reimbursement of those costs. HHSC declines to make changes to the rule text in response to this comment.

Comment: Several commenters provided comments opposed to the proposed allocation methodology stating that it limits the potential for a hospital that has uncompensated Medicaid costs to be reimbursed because the UC program is only for uninsured charity care.

Response: HHSC disagrees that the proposed allocation methodology inherently limits the potential for a hospital that has uncompensated Medicaid cost to be reimbursed because, to the extent that a hospital has uncompensated Medicaid costs and does not have a higher than typical payment-to-cost ratio, the provider would receive DSH payments that could compensate for unreimbursed Medicaid costs. However, HHSC does acknowledge that DSH is the payment of last option for Medicaid costs as the UC program is only for uninsured charity care. Therefore, as a result of these comments, HHSC will amend the rules upon adoption to incorporate an updated the allocation methodology to include a new standard DSH payment that will allocate payments to providers in an amount that is the greater of the Standard amount or the provider’s Medicaid shortfall (capping all payments at the provider’s state payment cap) to ensure that to the greatest extent possible Medicaid costs are reimbursed. HHSC updated 355.8065(g) and 355.8065(h) to

describe the methodology and updated 355.8065(b)(24) to point to the appropriate reference.

Comment: Several commenters provided comments opposed to the proposed allocation methodology stating that it treats hospitals homogenously when they are not.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. With regard to hospitals being treated homogenously, the rule has multiple different hospital classes and definitions because HHSC recognizes that different needs exist among different hospital classes.

Comment: Several commenters provided comments opposed to the proposed allocation methodology stating that it favors inefficient hospitals with higher costs resulting from their inability to better manage the level of care.

Response: HHSC disagrees that the proposed method favors inefficient hospitals with higher costs and declines to make changes to the rule text in response to this comment. The prior allocation methodology of days could result in providers prioritizing extending inpatient stays which is inefficient.

Comment: Multiple commenters provided comments opposed to the proposed allocation methodology stating that it introduces instability and unpredictability with a percentage of cost paid floor that changes every year.

Response: HHSC acknowledges the changes in funding for certain hospital classes and areas of the state, and the importance of stability and predictability for hospitals' financial health. As a result of these comments, HHSC updated the allocation methodology to include a new standard DSH payment before the cost pool. This addresses the commenters' concerns by lessening the total funds in the cost-based pool, resulting in a redistribution of funds as a result. HHSC updated 355.8065(g) and 355.8065(h) to describe the methodology and updated 355.8065(b)(24) to point to the appropriate reference.

Exclusion of advance UC payment in DSH percentage of cost calculation.

Comment: One commenter requested that HHSC consider excluding advance UC payments when calculating a hospital's percentage of reimbursed DSH costs, stating that doing so would not result in hospitals receiving reimbursement twice for the same costs as the UC program reimbursement is generally considered after the DSH program.

Response: HHSC disagrees and declines to make changes to the rule text as a result of this comment as the State Payment Cap has historically had an offset for UC advance payments that exceed UC only costs; this practice is continued in the percentage of cost covered calculation. This structure avoids reimbursing providers in DSH for costs that may have already been reimbursed in UC.

LIUR.

Comment: Multiple commenters commented against the change in the LIUR calculation to align with Federal LIUR calculation, stating that the updated calculation methodology could be devastating to many hospitals including rural hospitals. Commenters request for HHSC to retain the historical LIUR calculation.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment as the updated text is based on the Federal LIUR calculation which is a part of the Federal statute for the DSH program as described in 42 U.S.C. §1396r–4 (b)(3).

Comment: Several commenters made suggestions on the calculation methodology of the LIUR calculation stating that the LIUR calculation should include all Medicaid payments.

Response: HHSC declines to make changes to the rule text in response to this comment as the updated text is based on the Federal LIUR definition. HHSC will adhere to the Federal LIUR as described in 42 U.S.C. §1396r–4 (b)(3).

Local Provider Participation Funds.

Comment: Multiple commenters commented against the proposed changes stating that the changes would lead to strain on local provider participation funds (LPPFs) across the state as private hospitals' payments would shift from DSH to UC, which may lead to LPPFs being pushed to their caps.

Response: HHSC disagrees with this comment and declines to make changes to the rule text in response to this comment. HHSC has observed a willingness on the part of governmental entities that operate LPPFs to support through IGT all the varied Medicaid programs that have been created under the Medicaid state plan and the 1115 Waiver. HHSC has not received any requests asking HHSC to halt the growth in size of other programs, such as the Comprehensive Hospital Increased Reimbursement Program (CHIRP) or the Uncompensated Care program due to a lack of available local public funds. Rather, HHSC has consistently received requests for HHSC to pursue the approval of new and additional programs, which would utilize, at least in part, LPPF-derived local funds as the source of non-federal share. This indicates to HHSC that there is an availability of local funds sufficient to support hospital payment programs held by local governments that IGT for such programs. All governmental entities are required to comply with all federal and state laws and regulations related to the operation of LPPFs, including the limitations on the percentage of net patient revenue that may be assessed as a mandatory payment and HHSC designs programs and payment methodologies that are distinct from the method of finance that a local government may utilize. As result, no revision to the rule text was made in response to this comment.

Modeling.

Comment: Multiple commenters stated that the posted models on the DSH proposed changes included an error where private rural providers were included in the model for the public rural pool and requested an updated model based on 2023 data.

Response: Models are for informational purpose only and are not to be used as the basis of actual payments. However, HHSC identified due to the comment that the rule text did not describe participation of private rural hospitals in the rural pool in DSH. HHSC will amend the rule upon adoption to clarify that private hospitals are eligible to receive a percentage of the remaining rural pool if the public rural hospitals do not fully exhaust the rural public pool.

Recoupments.

Comment: Multiple commenters provided comments that they are against the retroactive application of the rule changes as it would lead to recoupment for many hospitals and lead to harm for hospitals that will be recouped based on the rule changes.

Response: HHSC disagrees that the rule changes proposed could be considered retroactive as any payments that providers have received to date are either interim or advance payments that are subject to being recouped at the time that the final payments are calculated for DSH and UC respectively. As such, the potential recoupments a provider might experience at the time of a final payment are fully within the current practice of rebalancing payments at the time of the final payment, which is made based upon the rule in effect at the time HHSC makes the final payment. However, HHSC understands that providers may have made budgetary assumptions that did not contemplate the proposed changes and, in response to commenters' concerns, HHSC will defer the application of the changes in 355.8065 to the DSH 2024 program period. Additionally, to assist providers with appropriate financial planning next year, HHSC will modify the advance payment methodology for DSH 2024 to pay providers based upon the estimated amount that they will receive in the 2024 final DSH payment in an effort to help providers avoid reliance on interim or advance payments that are inconsistent with the final payment methodology. HHSC updated 355.8065(a) and 355.8065(q)(5) in response to this comment.

General Comments.

Comments: Multiple providers provided general comments in support for all of the proposed rule changes.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: Several commenters provided general comments against the proposed rule changes including observations that there is a disparity between the DSH and UC funding sources, stating the UC reimbursements are diminished in comparison to DSH reimbursements.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. Qualifications for participation in the DSH program are updated to align with federal rules and UC reimbursement has increased by $600 million dollars annually so it is unclear what the basis is used for this comparison.

Rural definition.

Comment: Multiple commenters provided comment against the change in the rural definition and stated that the change would deny many hospitals of a vital payment. Several commenters have also requested maintaining the current rural definition or modifying the rural definition to be more inclusive and to account for population growth in Texas.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. It is HHSC's intention to align the rural definition to the Inpatient rate rule for consistency and transparency. A non-urban public definition is retained for Pass 3 in DSH.

Public Rural pool.

Comment: A commenter provided comment in support of the establishment of the public rural pool.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Timing.

Comment: Multiple commenters provided comments against the timing of the proposed rule changes, stating that the proposed rule changes are happening in the midst of many other program and rate changes affecting hospitals including the comprehensive hospital increase reimbursement program, enhanced ambulatory patient groups, inpatient rate rebasing, and changes in federal policies and that proposed changes were based on planning that began prior to the pandemic and public health emergency and that proposed changes should be revisited.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. HHSC has carefully evaluated options the last few years, both before and during the COVID-19 public health emergency. It is HHSC's intention to implement these changes at this time after careful analysis, and HHSC will continue to monitor the DSH and UC programs in subsequent years as we

administer the programs. Discussion of other program changes, audits, or federal policies is outside of scope of the current DSH/UC rule updates.

Comment: Several commenters provided comment in support of the timing of the proposed rule changes.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

IGT.

Comment: A commenter requested the treatment of IGT as costs in the DSH program and several commenters requested for the continuation and expansion of IGT credits in the UC program.

Response: HHSC acknowledges this comment. HHSC declines to expand the IGT credits for either DSH or UC and the treatment of IGT because these requests are outside the scope of the proposed rule changes. HHSC will take this into consideration for future analysis. No revision to the rule text was made in response to this comment.

Condition of Participation.

Comment: Multiple commenters provided comments in support of the new condition of participation requiring hospitals to participate in directed and supplemental Medicaid payment programs they are eligible for.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: A commenter requested the inclusion of language for exemption for hospitals that do not qualify for programs or would receive zero dollars or less from programs during the program year.

Response: HHSC agrees and has updated §355.8065(e)(9) and §355.8212(c)(1)(F) to include language outlining an exemption from this eligibility requirement for any directed or supplemental payment programs for which hospitals are eligible if their estimated payment will be $25,000 or less.

Comment: Several commenters provided comments against the condition of participation, stating that this requirement in effect creates application fees for the DSH program, especially for private IMDs that may receive less reimbursement through the program than the application fee for other programs.

Response: HHSC acknowledges this comment. HHSC updated §355.8065(e)(9) and §355.8212(c)(1)(F) to include language for an exemption from this eligibility requirement for any directed or supplemental payment programs for which

hospitals are eligible if their estimated payment from that program will be $25,000 or less.

Comment: A commenter requested the removal of application fees for Medicaid directed and supplemental payment programs.

Response: This is outside the scope of the proposed rule changes. No revision to the rule text was made in response to this comment.

Comment: A commenter provided feedback that IMDs are often not eligible for an average commercial incentive award (ACIA) increase in CHIRP and many IMDs have not applied for the ACIA component because they would not receive any additional benefit while being subjected to increased quality reporting requirements.

Response: HHSC acknowledges this feedback and has clarified the rule text in §355.8065(e)(9) and §355.8212(c)(1)(F) to state that hospitals are required to "enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all required components of those programs…" if the hospital is estimated to receive at least $25,000 from the program or the program component.

Comment: A commenter provided comment against the timing of the condition of participation stating that by proposing for this change to begin in program year 2024, the proposed change would occur more than six months after CHIRP enrollment period has ended for the 2024 program year. As this was known after the fact, HHSC should not penalize hospitals for failing to meet a condition of participation for program year 2024.

Response: HHSC agrees and has updated the rule text in §355.8065(e)(9) and §355.8212(c)(1)(F) to clarify that this requirement applies for all programs for which the enrollment period begins after this rule is effective.

Impact statements.

Comment: One commenter provided comments against the proposed rule changes, stating the proposed rule changes will affect local businesses, economies, and the State at large.

Response: HHSC disagrees with the comment. The rule does not directly regulate local business or economies, and the proposed rules did not impede the ability of any community or hospital within a community to receive payments if the hospital has a lower payment-to-cost ratio. Further, the same aggregate funding level was available to the State at large. Nevertheless, HHSC made changes in the adopted rule to mitigate funding shifts while still promoting stated policy goals.

DSRIP.

Comment: Multiple commenters have commented that DSH is not an appropriate vehicle for restoring hospitals' DSRIP payments because the goal of DSRIP was to incentivize performance which is not aligned with the purpose of the DSH program which supports hospitals serving a higher volume of Medicaid and low-income patients.

Response: HHSC acknowledges this comment but declines to make any changes to the rules as a result. Funding is complex with multiple interdependencies and DSH is not being used as the mechanism to fully replace the DSRIP program, but the changes to DSH are in part necessary as the impact of other programs that were designed to replace DSRIP have resulted in imbalance in overall hospital financing stability.

Comment: Several commenters stated that the DSRIP funding was inequitably allocated and noted that numerous private providers were unable to participate in DSRIP. The commenters further noted that as such the proposed changes perpetuate the inequity by shifting funds away from certain hospital classes to other hospital classes.

Response: The allocation of DSRIP funding and prior DSRIP participation is outside the scope of the current proposed rules. In the development of the proposed rules, HHSC examined the DSH and UC programs in their entirety with the intent of ensuring that the funds are allocated in accordance with their purpose, where the funds were most likely to benefit a large number of Texans receiving care, and in accordance with established state policy goals. No changes were made in response to this comment.

Comment: One commenter stated that they disagree with the assessment that large urban public hospitals have not already replaced their DSRIP funding.

Response: HHSC disagrees with the commenter. Pursuant to HHSC's Rider 15(j) report, our analysis indicates that the reimbursement levels for certain classes of hospitals including large urban publics is not at an equivalent level overall compared to FFY 2020, the last year that DSRIP was operational. No changes were made in response to this comment.

Private IMDs.

Comment: Multiple commenters have submitted comments against the proposed rule changes, stating that the changes would negatively impact private IMDs. Commenters requested protection for private IMD hospitals through creation of a protected private IMD pool, maintaining state hospitals allocation at 90 percent of their state payment caps in DSH to avoid future recoupments and private IMDs exceeding the statewide aggregate IMD limit and stated that the proposed rule would reduce non-state IMDs before reducing state IMD DSH payments for the IMD allotment cap which would further diminish non-state IMDs in participation of the DSH Program.

Response: HHSC has added a new standard DSH pool to provide a minimum payment to all hospitals, including private IMDs, that have room under their state payment cap. However, IMD hospitals can only receive a limited portion of the DSH funds under federal statute. HHSC annually determines the percentage of the state payment caps that will be paid to state-owned providers. HHSC will consider the impact to non-state-owned IMDs as those amounts are established each year, as is the current practice. HHSC updated 355.8065(b)(22), 355.8065(g) and 355.8065(h) in response to this comment.

CHIRP adjustment appeal.

Comment: Two commenters submitted comments requesting HHSC to allow hospitals to use historical UHRIP /CHIRP payment projections and actual payments in appeals of HHSC's CHIRP adjustments in the DSH and UC programs.

Response: This is outside the scope of the proposed rule changes. No revision to the rule text was made in response to this comment.

Graduate Medical Education Payments.

Comment: One commenter is in support of the proposed DSH methodology and states that inclusion of Medicaid GME payments in the proposed DSH rules is appropriate and further states that while teaching hospitals are in support of the proposed changes, teaching hospitals are still left with unfunded healthcare workforce teaching and training costs within GME.

Response: HHSC appreciates the support for the proposed amendment and acknowledges the comment on the needs of teaching hospitals. In the amended rule text, the standard DSH payment for hospitals with residents will be a higher payment than hospitals without residents.

Ambiguous Rule text.

Comment: Several commenters submitted comments against the ambiguity of the wording of § 355.8065(c)(2)(B) and (c)(3)(B), stating that the words "may" and "if necessary" does not provide sufficient justification and allows HHSC too much discretion to make changes to the payment ceiling calculations of hospitals.

Response: HHSC disagrees with the suggested update. The commenters had mistakenly provided the incorrect rule text reference for this comment. No revision to the § 355.8065 rule text was made in response to this comment. However, HHSC believes that the commenters intention was to reference §355.8066(c)(2)(B) and (c)(3)(B). As a result, HHSC has review the §355.8066(c)(2)(B) and (c)(3)(B) rule text and amended the "may" to "shall" and removed "if necessary" for greater clarity.

Regarding §355.8066, concerning Hospital-Specific Limit Methodology:

Lesser of methodology.

Comment: Multiple commenters submitted comments in support of the lesser of methodology for the State Payment Cap.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters submitted comments against the lesser of methodology citing that it is unnecessarily complicated and requesting the use of the MACPAC definition as the sole SPC.

Response: HHSC disagrees and declines to make revisions to the rule as a result of this comment. The lesser of methodology protects hospitals against future recoupments which outweighs the noted complexity of the methodology.

Comment: One commenter submitted comment against the lesser of methodology and stated that HHSC's proposal to continue to use the full-offset state-payment cap calculation in the lesser of approach goes against the cost reporting principles of the DSH HSL calculation as supported by the now withdrawn CMS FAQs 33 and 34.

Response: HHSC disagrees. The state has the authority to calculate a state-specific limit, which is the state payment cap, as a basis for distributing interim DSH funds. CMS has adopted rules that describe how the final HSL is calculated, and HHSC is adhering to federal direction on the DSH audit.

Comment: Multiple commenters stated that using the lesser of methodology is inequitable because it applies different standard calculations across hospitals with some hospitals including dual eligible populations in their percentage of cost calculations, while others will have that population excluded. These commenters requested the use of only the MACPAC SPC.

Response: HHSC disagrees and declines to make revisions to the rule as a result of this comment. The lesser of methodology protects hospitals from recoupments, and the cost and payments used in the percentage of cost covered pool correspond to the minimum SPC.

Exceptions.

Comment: One commenter requested that HHSC revise §355.8066(c)(3)(D) and (d)(3) before adoption to remove the requirement that hospitals request HHSC determine whether they meet the 97th percentile exception; and add language that HHSC will rely on the eligibility determination made by CMS.

Response: HHSC agrees and has revised §355.8066(c)(3)(D) and (d)(3) to include the statement "HHSC will adhere to CMS' determination on eligibility for exceptions authorized by Section 1923(g) of the Social Security Act."

Regarding §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care:

Rural Definition

Comment: A commenter stated that HHSC did not change from 2010 to 2020 census definition for the standard definition of rural hospital.

Response: HHSC agrees and has revised §355.8212(b)(17)(A) to state "most recent decennial census" instead of citing the 2010 U.S. Census to conform with anticipated definition changes that will also be made to the inpatient rate rule definitions.

Charity Care calculation.

Comment: A commenter provided a suggestion for rural providers to be allowed to choose between a cost spread methodology or their overall Cost to Charge Ratio as reported on S-10 for charity care cost calculations.

Response: This is outside the scope of the proposed rule changes. No revision to the rule text was made in response to this comment.

HICH.

Comment: Multiple commenters submitted comments in support of the establishment of the HICH pool.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: One commenter suggested that the HICH ratio should exclude uninsured charity charges and duplicates in the numerator and simply utilize DSH uninsured charges for total uninsured charges in the numerator to calculate uninsured volume, and that the HICH ratio's denominator should equal total charges drawn from the same time period as total uninsured charges in the numerator.

Response: HHSC disagrees and declines to make changes to the rule text as a result. As the HICH pool and the HICH ratio is a part of the UC program which reimburses hospitals for uninsured charity care, the usage and inclusion of uninsured charity charges is appropriate, as is the consideration of any duplicated uninsured charges from the DSH and UC programs to ensure accuracy in the calculation of the numerator. The intention of the HICH pool is to allocate funds amongst hospitals with a high proportion of uncompensated care charges, using

total allowable revenue would provide a more accurate picture of the proportion of uncompensated care charges than the suggested total charges from the same time period as the denominator.

Comment: Multiple commenters requested modification of HICH pool eligibility. Requests for HICH pool eligibility qualifications included requests to include non-transferring and transferring public hospitals and request to exclude rural public hospitals.

Response: HHSC declines to add transferring and non-transferring public hospitals to the HICH pool eligibility based on the comments. However, HHSC understands that the 30 percent HICH ratio may be too restrictive and will be lowering that threshold to 27.5 percent in 355.8212(f)(2)(D)(ii).

Rule text language.

Comment: A commenter requested retaining the language "to that hospital and private hospitals" in 1 TAC §355.8212(g)(2)(A)(iv) to add clarity related to transferring public hospitals.

Response: HHSC agrees and has retained the language "to that hospital and private hospitals" in §355.8212(g)(2)(A)(iv). This update to the rule does not change the calculations or methodology of the updated rule text.

Regional Healthcare partnership.

Comment: A commenter stated that the removal of Regional Healthcare partnership (RHP) from the rule would contradict the waiver standard term and condition (STC) (38)(a)(ii)(2) that requires a hospital to participate in an RHP in order to qualify for UC payments and that a waiver amendment to that STC should be considered.

Response: HHSC has submitted a request for a technical correction for the waiver to update the standard term and condition (STC) to align with the removal of Regional Healthcare partnership (RHP) and requirement of affiliation agreements. Until such a time as the STC technical correction is approved by CMS, 1 TAC §355.8212(a) continues to require providers to comply with all underlying federal requirements, including the STCs.

IMD age exclusion.

Comment: Several commenters stated that the rule changes disadvantages IMDs in particular because in addition to expected reduction in DSH payments, IMDs are subject to the age exclusion for charity costs for patients ages 21-64 in the UC program.

Response: HHSC did not propose any changes for this topic, but we will take this into consideration for future rule making. No revision to the rule text was made in response to this comment.

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32.

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

ADDITIONAL INFORMATION

For further information, please contact PFD_Hospitals@hhsc.state.tx.us or (737) 867-7813.

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

§355.8065. Disproportionate Share Hospital Reimbursement Methodology.

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

(b) Definitions.

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

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

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

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

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

(6) Charity care--The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to indigent individuals, either directly or through other nonprofit or public

outpatient clinics, hospitals, or health care organizations. A hospital must set the income level for eligibility for charity care consistent with the criteria established in §311.031, Texas Health and Safety Code.

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

(8) Children's hospital--A hospital that is a Children's hospital as defined in §355.8052 of this chapter (relating to Inpatient Hospital Reimbursement).

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

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

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

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

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

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

(15) Hospital-specific limit (HSL) --The maximum payment amount, as applied to payments made during a prior DSH program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured. The hospital-specific limit is calculated using the methodology described in §355.8066 of this division (relating to State Payment Cap and Hospital-Specific Limit Methodology) using actual cost and payment data from the DSH program year.

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

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

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

(19) Inpatient day--Each day that an individual is an inpatient in the hospital,

whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The term includes observation days, rehabilitation days, psychiatric days, and newborn days. The term does not include swing bed days or skilled nursing facility days.

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

(21) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness, defined in §1905(i) of the Social Security Act. IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.8060 of this division (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities) and §355.761 of this chapter (relating to Reimbursement Methodology for Institutions for Mental Diseases (IMD).

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

(~~22~~23) Intergovernmental transfer (IGT)--A transfer of public funds from a governmental entity to HHSC.

(~~23~~24) Low-income days--Number of inpatient days attributed to indigent patients~~,~~ are calculated using the following methodology. Low-income days are equal to the hospitals low-income utilization rate as calculated in subsection (d)(2) of this section multiplied by the hospitals total inpatient days~~calculated as described in subsection (h)(4)(A)(ii) of this section~~.

(~~24~~25) Low-income utilization rate--A ratio, calculated as described in subsection (d)(2) of this section, that represents the hospital's volume of inpatient charity care relative to total inpatient services.

(~~25~~26) Mean Medicaid inpatient utilization rate--The average of Medicaid inpatient utilization rates for all hospitals that have received a Medicaid payment for an inpatient claim, other than a claim for a dually eligible patient, that was adjudicated during the relevant DSH data year.

(~~26~~27) Medicaid contractor--Fiscal agents and managed care organizations with which HHSC contracts to process data related to the Medicaid program.

(~~27~~28) Medicaid cost report--Hospital and Hospital Health Care Complex Cost Report (Form CMS 2552), also known as the Medicare cost report.

(~~28~~29) Medicaid hospital--A hospital meeting the qualifications set forth in §354.1077 of this title (relating to Provider Participation Requirements) to participate in the Texas Medicaid program.

(~~29~~30) Medicaid inpatient utilization rate (MIUR)--A ratio, calculated as described in subsection (d)(1) of this section, that represents a hospital's volume of Medicaid inpatient services relative to total inpatient services.

(~~30~~31) MSA--Metropolitan Statistical Area as defined by the United States Office of Management and Budget. MSAs with populations greater than or equal to 137,000, according to the most recent decennial census, are considered "the largest MSAs."

(~~31~~32) Non-federal percentage--The non-federal percentage equals one minus the federal medical assistance percentage (FMAP) for the program year.

(~~32~~33) Non-rural hospital--Any hospital that does not meet the definition of rural hospital as defined in §355.8052 of this chapter.

(~~33~~34) Non-urban public hospital--A hospital other than a transferring public hospital that is:

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

(B) operated under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county, and the hospital and governmental entity have both signed an attestation that they wish the hospital to be treated as a public hospital for all purposes under both this section and §355.8212 of this subchapter (relating to Waiver Payments to Hospitals for Uncompensated Charity Care).

(~~34~~35) Obstetrical services--The medical care of a woman during pregnancy, delivery, and the post-partum period provided at the hospital listed on the DSH application.

(~~35~~36) PMSA--Primary Metropolitan Statistical Area as defined by the United States Office of Management and Budget.

(~~36~~37) Public funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(~~37~~38) Public Health Hospital (PHH)--The Texas Center for Infectious Disease or any successor facility operated by the Department of State Health Services.

(~~38~~39) Ratio of cost-to-charges--A ratio that covers all applicable hospital costs and charges relating to inpatient care and outpatient care. This ratio will be calculated for inpatient and outpatient services and, does not distinguish between payer types such as Medicare, Medicaid, or private pay.

(~~39~~40) Rural public hospital--A hospital that is a rural hospital as defined in §355.8052 of this chapter and is either:

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

(B) is under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county and the hospital and governmental entity have both signed an attestation that they wish to be treated as a public hospital for all purposes under this section.

(~~40~~41) State institution for mental diseases (State IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness defined in §1905(i) of the Social Security Act and that is owned and operated by a state university or other state agency. State IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.761 of this chapter.

(~~41~~42) State-owned hospital--A hospital that is defined as a state IMD, state-owned teaching hospital, or a Public Health Hospital (PHH) in this section.

(~~42~~43) State-owned teaching hospital--A hospital that is a state-owned teaching hospital as defined in §355.8052 of this chapter.

(~~43~~44) State payment cap--The maximum payment amount, as applied to payments that will be made for the DSH program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured. The state payment cap is calculated using the methodology described in §355.8066 of this title (relating to Hospital-Specific Limit Methodology) using interim cost and payment data from the DSH data year.

(~~44~~45) Tax Revenue--Funds derived from local taxes that are assessed and payable to a hospital or a hospital district. For purposes of this section, Tax Revenue does not include mandatory payments received by a local governmental entity that is authorized by a relevant chapter of Subtitle D, Title 4, Texas Health and Safety Code, to operate a Local Provider Participation Fund (LPPF).

(~~45~~46) Third-party coverage--Creditable insurance coverage consistent with the definitions in 45 Code of Federal Regulations (CFR) Parts 144 and 146, or coverage based on a legally liable third-party payer.

(~~46~~47) Total Medicaid inpatient days--Total number of inpatient days based on adjudicated claims data for covered services for the relevant DSH data year.

(A) The term includes:

(i) Medicaid-eligible days of care adjudicated by managed care organizations or HHSC;

(ii) days that were denied payment for spell-of-illness limitations;

(iii) days attributable to individuals eligible for Medicaid in other states, including dually eligible patients;

(iv) days with adjudicated dates during the period; and

(v) days for dually eligible patients for purposes of the MIUR calculation described in subsection (d)(1) of this section.

(B) The term excludes:

(i) days attributable to Medicaid-eligible patients ages 21 through 64 in an IMD;

(ii) days denied for late filing and other reasons; and

(iii) days for dually eligible patients for purposes of the following calculations:

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

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

(~~47~~48) Total Medicaid inpatient hospital payments--Total amount of Medicaid funds that a hospital received for adjudicated claims for covered inpatient services during the DSH data year. The term includes payments that the hospital received:

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

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

(~~48~~49) Total state and local subsidies--Total amount of state and local payments that a hospital received for inpatient and outpatient care during the DSH data year. The term includes payments under state and local programs that are funded entirely with state general revenue funds and state or local tax funds, such as County Indigent Health Care, Children with Special Health Care Needs, and Kidney Health Care. The term excludes payment sources that contain federal dollars such as Medicaid payments, Children's Health Insurance Program (CHIP) payments funded under Title XXI of the Social Security Act, Substance Abuse and Mental Health Services Administration, Ryan White Title I, Ryan White Title II, Ryan White Title III, and contractual discounts and allowances related to TRICARE, Medicare, and Medicaid. The term also includes tax revenue.

(~~49~~50) Transferring public hospital--A hospital that is owned and operated by one of the following entities: the Dallas County Hospital District, the El Paso County Hospital District, the Harris County Hospital District, the Tarrant County Hospital District, or the University Health System of Bexar County.

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

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

(2) have received a Medicaid payment for an inpatient claim, other than a claim

for a dually eligible patient, that was adjudicated during the relevant DSH data year; and

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

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

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

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

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

(E) Merged Hospitals.

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

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

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

(ii) If the requirements of clause (i) are not met, HHSC will not consider the merger for purposes of determining eligibility or calculating a hospital's DSH program year payments under this section. Until HHSC determines that the hospitals are eligible for payments as a merged hospital, each of the merging hospitals will continue to receive any DSH payments to which it was entitled prior to the merger.

(d) Qualification. For each DSH program year, in addition to meeting the eligibility requirements, applicants must meet at least one of the following qualification criteria, which are determined using information from a hospital's application, from HHSC, or from HHSC's Medicaid contractors, as specified by HHSC.

(1) Medicaid inpatient utilization rate. A hospital's Medicaid inpatient utilization rate is calculated by dividing the hospital's total Medicaid inpatient days by its total inpatient census days for the DSH data year.

(A) A hospital located outside an MSA or PMSA must have a Medicaid inpatient utilization rate greater than the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

(B) A hospital located inside an MSA or PMSA must have a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

(2) Low-income utilization rate. A hospital must have a low-income utilization rate greater than 25 percent. For purposes of paragraph (2) of this section, the term "low-income utilization rate" is calculated using the calculation described in 42 U.S.C. §1396r–4 (b)(3).

(3) Total Medicaid inpatient days.

(A) A hospital must have total Medicaid inpatient days at least one standard deviation above the mean total Medicaid inpatient days for all hospitals participating in the Medicaid program, except a hospital in a county with a population of 290,000 persons or fewer, according to the most recent decennial census, must have total Medicaid inpatient days at least 70 percent of the sum of the mean total Medicaid inpatient days for all hospitals in this subset plus one standard deviation above that mean.

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

(4) State-owned hospitals. State-owned hospitals that do not otherwise qualify as disproportionate share hospitals under this subsection will be deemed to qualify. A hospital deemed to qualify must still meet the eligibility requirements under subsection (c) of this section and the conditions of participation under subsection (e) of this section.

(5) Merged hospitals. Merged hospitals are subject to the application requirement in subsection (c)(3)(E) of this section. In accordance with requirements in subsection (c)(3)(E) of this section, HHSC will aggregate the data used to determine qualification under this subsection from the merged hospitals to determine whether the single Medicaid provider that results from the merger qualifies as a Medicaid disproportionate share hospital.

(6) Hospitals with multiple Medicaid provider numbers. Hospitals that held a single Medicaid provider number during the DSH data year, but later added one or more Medicaid provider numbers. Upon request, HHSC will apportion the Medicaid DSH funding determination attributable to a hospital that held a single Medicaid provider number during the DSH data year (data year hospital), but subsequently added one or more Medicaid provider numbers (new program year hospital(s)) between the data year hospital and its associated new program year hospital(s). In these instances, HHSC will apportion the Medicaid DSH funding determination for the data year hospital between the data year hospital and the new program year hospital(s) based on estimates of the division of Medicaid inpatient and low income utilization between the data year hospital and the new program year hospital(s) for

the program year, so long as all affected providers satisfy the Medicaid DSH conditions of participation under subsection (e) of this section and qualify as separate hospitals under subsection (d) of this section based on HHSC's Medicaid DSH qualification criteria in the applicable Medicaid DSH program year. In determining whether the new program year hospital(s) meet the Medicaid DSH conditions of participation and qualification, proxy program year data may be used.

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

(1) Two-physician requirement.

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

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

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

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

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

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

(3) Trauma system.

(A) The hospital must be in active pursuit of designation or have obtained a trauma facility designation as defined in §780.004 and §§773.111 - 773.120, Texas Health and Safety Code, respectively, and consistent with 25 TAC §157.125 (relating to Requirements for Trauma Facility Designation) and §157.131 (relating to the Designated Trauma Facility and Emergency Medical Services Account). A hospital that has obtained its trauma facility designation must maintain that designation for the entire DSH program year.

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

(C) The following hospital types are exempted from the condition of

participation described in this paragraph: Children's Hospitals, IMDs, Public Health Hospitals, and State IMDs.

(4) Maintenance of local funding effort. A hospital district in one of the state's largest MSAs or in a PMSA must not reduce local tax revenues to its associated hospitals as a result of disproportionate share funds received by the hospital. For this provision to apply, the hospital must have more than 250 licensed beds.

(5) Retention of and access to records. A hospital must retain and make available to HHSC records and accounting systems related to DSH data for at least five years from the end of each DSH program year in which the hospital qualifies, or until an open audit is completed, whichever is later.

(6) Compliance with audit requirements. A hospital must agree to comply with the audit requirements described in subsection (o) of this section.

(7) Merged hospitals. Merged hospitals are subject to the application requirement in subsection (c)(3)(E) of this section. If HHSC receives documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, the merged entity must meet all conditions of participation. If HHSC does not receive the documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, any proposed merging hospitals that are receiving DSH payments must continue to meet all conditions of participation as individual hospitals to continue receiving DSH payments for the remainder of the DSH program year.

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

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

(A) a hospital is not required to enroll, participate in, and comply with the requirements:

(i) of a program without multiple components if the hospital's estimated payment from the entire program is less than $25,000; or

(ii) of a program's component for programs that have multiple components if the hospital's estimated payment from the program's component is less than $25,000; and

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

(f) State payment cap and hospital-specific limit calculation. HHSC uses the methodology described in §355.8066 of this title to calculate a state payment cap for each Medicaid hospital that applies and qualifies to receive payments for the DSH program year under this section, and a hospital-specific limit for each hospital that received payments in a prior program year under this section. For payments for each DSH program year beginning before October 1, 2017, the state payment cap calculated as described in §355.8066 will be reduced by the amount of prior payments received by each participating hospital for that DSH program year. These prior payments will not be considered anywhere else in the calculation.

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

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

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

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

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

(A) The remaining available DSH funds equal the lesser of the funds as defined in subsection (b)(2) of this section less funds expended under paragraph (1), ~~and~~ (2), and (3) of this subsection or the sum of remaining qualifying hospitals' state payment caps.

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

(h) DSH payment calculation.

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

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

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

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

(2) Establishment of DSH funding pools for non-state hospitals. From the amount of remaining DSH funds determined in subsection (g)(3) of this section, HHSC will establish three DSH funding pools.

(A) Pool One.

(i) Pool One is equal to the sum of the remaining available general revenue funds and associated federal matching funds.

(ii) Pool One payments are available to all non-state-owned hospitals, including non-state-owned public hospitals.

(B) Pool Two.

(i) Pool Two is equal to the lesser of:

(I) the amount of remaining DSH funds determined in subsection (g)(3) of this section less the amount determined in paragraph (2)(A) of this subsection multiplied by the FMAP in effect for the program year; or

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

(ii) Pool Two payments are available to all non-state-owned hospitals except for any transferring public hospitals as defined in subsection (b) of this section; or non-urban public hospital as defined in subsection (b) of this section that does not transfer any funds to HHSC for Pool Three as described in subparagraph (C)(iii) of this paragraph.

(C) Pool Three.

(i) Pool Three is equal to the sum of intergovernmental transfers for DSH payments received by HHSC from governmental entities that own and operate transferring public hospitals and non-urban public hospitals.

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

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

(I) Non-urban public hospitals. Each governmental entity that operates or is under a lease contract with a non-urban public hospital is responsible for

funding the non-federal share of the hospital's DSH payments from Pool Two (calculated as described in paragraphs (3~~4~~) and (4) of this subsection) to that hospital.

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

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

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

(A) HHSC will first determine the state payment cap for the hospital in accordance with §355.8066 of this division, including any year-to-date uncompensated-care (UC) payments as defined in §355.8212 of this subchapter (relating to Waiver Payments to Hospitals for Uncompensated Charity Care) attributable to the state payment cap.

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

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

(I) the hospital’s Medicaid shortfall; or

(II) a standard DSH payment.

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

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

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

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

(A) ~~HHSC will first determine the state payment cap for the hospital in accordance with §355.8066, including any year-to-date uncompensated care (UC) payments as defined in §355.8212 of this subchapter (relating to Waiver Payments to Hospitals for Uncompensated Charity Care) attributable to the state payment cap.~~

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

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

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

~~(4) Distribution and payment calculation for Pools One and Two.~~

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

(~~B~~E) If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for a Pool One and Two secondary payment~~any DSH payments from the DSH funding pools for non-state hospitals~~.

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

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

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

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

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

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

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

(i) For each transferring public hospital:

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

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

(ii) For each Non-urban public hospital:

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

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

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

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

(i) Sum the intergovernmental transfers made on behalf of all transferring public hospitals.

(ii) For each transferring public hospital, divide the intergovernmental transfer made on behalf of that hospital by the sum of the intergovernmental transfers made on behalf of all transferring public hospitals from clause (i) of this subparagraph.

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

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

(v) Multiply the result from clause (ii) of this subparagraph by the result from clause (iv) of this subparagraph for each transferring public hospital. The result is the Pass One secondary payment from Pool Three for that hospital.

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

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

(6) Pass Two - Secondary redistribution of amounts in excess of state payment caps for Pool Three. For each hospital that received a Pass One initial or secondary payment from Pool Three, HHSC will sum the result from paragraph (4) of this subsection and the result from paragraph (5) of this subsection to determine the hospital's total projected DSH payment. In the event this sum plus any previous payment amounts for the program year exceeds a hospital's state payment cap, the payment amount will be reduced such that the sum of the payment amount plus any previous payment amounts is equal to the state payment cap. HHSC will sum all resulting excess funds and redistribute that amount to qualifying non-state-owned hospitals eligible for payments from Pool Three that have projected payments, including any previous payment amounts for the program year, below its state payment caps. For each such hospital, HHSC will:

(A) subtract the hospital's projected DSH payment plus any previous payment amounts for the program year from its state payment cap;

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

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

(i) If the sum of subparagraph (B) of this paragraph is less than or equal to the total excess funds, HHSC will pay all such hospitals up to the state payment cap.

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

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

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

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

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

(A) HHSC will determine an allocation percentage such that all rural public hospitals receive a uniform percentage of the costs covered to fully utilize the rural public all funds allocation. The percentage of cost covered will consider all previous DSH payments for the program year, including the funds for the non-state hospitals.

(B) If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for any DSH payments from the rural public hospital pool.

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

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

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

(A) If any funds remain from the rural public pool described in paragraph (7) of this subsection, HHSC will allocate a percentage of the remaining funds to rural private hospitals.

(B) HHSC will determine an allocation percentage such that all rural private hospitals receive a uniform percentage of the costs covered to fully utilize the rural public federal funds allocation. The percentage of cost covered will consider all previous DSH payments for the program year, including the funds for the non-state hospitals.

(C) If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for any DSH payments from the rural private hospital pool.

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

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

(F) Any remaining funds from the percentage allocation described in subparagraph (A) of this paragraph and any undistributed funds from this pool will be redistributed back into the pool two secondary payment as described in paragraph (4) of this subsection.

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

(A) For each non-urban public hospital that met the funding requirements described in paragraph (2)(C)(iii)(I) of this subsection, HHSC will determine the projected payment amount plus any previous payment amounts for the program year calculated in accordance with paragraphs (4) - (~~7~~8) of this subsection, as appropriate.

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

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

(D) Prior to processing any full or partial DSH payment that includes an additional allocation of DSH funds as described in this paragraph, HHSC will determine if such a payment would cause total DSH payments for the full or partial payment to exceed the available DSH funds for the payment as described in subsection (b)(2) of this section. If HHSC makes such a determination, it will reduce the DSH payment amounts non-urban public hospitals are eligible to receive through the additional allocation as required to remain within the available DSH funds for the payment. This reduction will be applied proportionally to all additional allocations. HHSC will:

(i) determine remaining available funds by subtracting payment amounts for all DSH hospitals calculated in paragraphs (4) - (~~7~~8) of this subsection from the amount in subsection (g)(3) of this section;

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

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

(iv) multiply each intergovernmental transfer supported payment from subparagraph (C) of this paragraph by the proportion statistic determined in clause (iii) of this subparagraph. The resulting product will be the additional allowable allocation for the payment.

(E) Non-urban public hospitals that do not meet the funding requirements of paragraph (2)(C)(iii)(I) of this subsection are not eligible for participation on Pass

Three.

(~~9~~10) Reallocating funds if hospital closes, loses its license or eligibility, or files bankruptcy. If a hospital closes, loses its license, loses its Medicare or Medicaid eligibility, or files bankruptcy before receiving DSH payments for all or a portion of a DSH program year, HHSC will determine the hospital's eligibility to receive DSH payments going forward on a case-by-case basis. In making the determination, HHSC will consider multiple factors including whether the hospital was in compliance with all requirements during the program year and whether it can meet the audit requirements described in subsection (o) of this section. If HHSC determines that the hospital is not eligible to receive DSH payments going forward, HHSC will notify the hospital and reallocate that hospital's disproportionate share funds to state hospitals then amongst all DSH hospitals in the same category that are eligible for additional payments.

(~~10~~11) HHSC will give notice of the amounts determined in this subsection.

(~~11~~12) The sum of the annual payment amounts for state owned and non-state owned IMDs are summed and compared to the federal IMD limit. If the sum of the annual payment amounts exceeds the federal IMD limit, the non-state owned IMDs are reduced first on a pro-rata basis so that the sum is equal to the federal IMD limit. In the case that the non-state owned IMD payments are eliminated and the payments for the state owned IMD still exceed the federal IMD limit, then the state owned IMD payments will be reduced on a pro-rata basis until they equal the federal IMD limit.

(~~12~~13) For any DSH program year for which HHSC has calculated the hospital-specific limit described in §355.8066(c)(2) of this chapter, HHSC will compare the interim DSH payment amount as calculated in subsection (h) of this section to the hospital-specific limit.

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

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

(i) Hospital located in a state or federal natural disaster area. A hospital that is located in a county that is declared a state or federal natural disaster area and that was participating in the DSH program at the time of the natural disaster may request that HHSC determine its DSH qualification and interim reimbursement payment amount under this subsection for subsequent DSH program years. The following conditions and procedures will apply to all such requests received by HHSC.

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

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

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

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

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

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

(k) Disproportionate share funds held in reserve.

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

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

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

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

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

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

(i) be sent to HHSC's Director of Hospital Finance, Provider Finance Department;

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

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

(B) The review is:

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

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

(iii) not conducted as an adversarial hearing.

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

(l) Recovery and redistribution of DSH funds. As described in subsection (o) of this section, HHSC will recoup any overpayment of DSH funds made to a hospital, including an overpayment that results from HHSC error or that is identified in an audit. Recovered funds will be redistributed as described in subsection (p) of this section.

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

(n) Voluntary withdrawal from the DSH program.

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

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

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

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

(o) Audit process.

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

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

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

(i) The Medicaid cost report;

(ii) Medicaid Management Information System data; and

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

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

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

(E) HHSC will recoup any overpayment of DSH funds made to a hospital that is identified in the independent certified audit as described in this subsection and will redistribute the recouped funds to DSH providers in accordance with subsection (p) that received interim payments, subject to the hospital-specific limits, as described in subsections (q) and (l) of this section.

(F) Review of preliminary audit finding of overpayment.

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

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

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

(II) The request must allege the specific factual or calculation errors

the hospital contends the auditors made that, if corrected, would change the preliminary audit finding.

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

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

(iii) The review is:

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

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

(III) not an adversarial hearing.

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

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

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

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

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

(1) For DSH program years 2011-2017 (October 1, 2011 – September 30, 2017)

and for DSH program years 2020 and after (October 1, 2019 and after), HHSC will use the following methodology to redistribute recouped funds:

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

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

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

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

(A) To calculate a weight that will be applied to all non-state providers, HHSC will divide the final hospital-specific limit described in §355.8066(c)(2) of this division by the final hospital-specific limit described in §355.8066(c)(2) of this division that has not offset payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer. HHSC will add 1 to the quotient. Any non-state provider that has a resulting weight of less than 1 will receive a weight of 1.

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

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

(q) Advance Payments

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

payment amount for that year.

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

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

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

(5) The amount of the advance payments:

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

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

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

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

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

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

§355.8066. State Payment Cap and Hospital-Specific Limit Methodology.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to calculate a hospital-specific limit for each Medicaid hospital participating in either the Disproportionate Share Hospital (DSH) program, described in §355.8065 of this division (relating to Disproportionate Share Hospital Reimbursement Methodology), or in the Texas Healthcare Transformation and Quality Improvement Program (the waiver), described in §355.8201 of this subchapter (relating to Waiver Payments to Hospitals for Uncompensated Care) and §355.8212 of this subchapter (relating to Waiver Payments to Hospitals for Uncompensated Charity Care).

(b) Definitions.

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

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

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

(4) Demonstration Year--The time period described in the definition for "Demonstration year" in §355.8212 of this subchapter.

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

(6) DSH and Uncompensated Care (UC) Application--The HHSC data collection tool completed by each hospital applying for participation in DSH or UC and used by HHSC to calculate the state payment cap and hospital-specific limit, as described in this section, and to estimate the hospital's DSH and UC payments for the program year, as described in §355.8065 of this division (relating to Disproportionate Share Hospital Reimbursement Methodology) and §355.8212 of this subchapter. A hospital may be required to complete multiple applications due to different data requirements between the state payment cap and hospital-specific limit calculations.

(7) DSH and UC Application Request Form--An online survey sent to hospitals or its representatives to request a DSH and UC application and to collect information necessary to prepopulate the DSH and UC application.

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

(9) Federal Fiscal Year (FFY)--The 12-month period beginning October 1 and ending September 30. The period also corresponds to the waiver demonstration year.

(10) Full-Offset Payment Ceiling--The maximum payment cap derived using the full-offset methodology as described in subsection (c)(1) of this section.

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

(12) Hospital-specific limit--The maximum payment amount authorized by Section 1923(g) of the Social Security Act that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured for payments made during a prior program year. The amount is calculated as described in subsection (d) of this section using actual cost and payment data from that period. The term does not apply to payment for costs of providing services to non-Medicaid-eligible individuals who

have third-party coverage; and costs associated with pharmacies, clinics, and physicians. The calculation of the hospital-specific limit must be consistent with federal law.

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

(14) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness, defined in §1905(i) of the Social Security Act. IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.8060 of this division (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities) and §355.761 of this chapter (relating to Reimbursement Methodology for Institutions for Mental Diseases (IMD)).

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

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

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

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

(19) Medicaid payor type--The categories of payors on Medicaid claims. These are categorized in the DSH and UC application as Medicaid, where Medicaid is the sole payor, Medicare, for claims associated with the care of dually eligible patients, and other insurance, for claims for which the hospital received payment from a third-party payor for a Medicaid-enrolled patient.

(20) Outpatient charges--Amount of gross outpatient charges related to the applicable data year and used in the calculation of a payment limit or cap.

(21) Program year--The 12-month period beginning October 1 and ending September 30. The period corresponds to the waiver demonstration year.

(22) Recoupment Prevention Payment Ceiling--The maximum payment cap derived using the methodology described in subsection (c)(2) of this section that considers Medicaid only costs and payments in the methodology.

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

subsection (c) of this section using interim cost and payment data from the data year. The term does not apply to payment for costs of providing services to non-Medicaid-eligible individuals who have third-party coverage or costs associated with pharmacies, clinics, and physicians.

(24) The waiver--The Texas Healthcare Transformation and Quality Improvement Program, a Medicaid demonstration waiver under §1115 of the Social Security Act that was approved by CMS. Pertinent to this section, the waiver establishes a funding pool to assist hospitals with uncompensated-care costs.

(25) Third-party coverage--Creditable insurance coverage consistent with the definitions in 45 Code of Federal Regulations (CFR) Parts 144 and 146, or coverage based on a legally liable third-party payor.

(26) Total state and local subsidies--Total state and local subsidies is defined in §355.8065 of this division.

(27) Uncompensated Care Hospital--A hospital identified by HHSC that meets the UC program eligibility criteria to receive a payment as defined in §355.8212 of this subchapter.

(28) Uncompensated-care waiver payments--Payments to hospitals participating in the waiver that are intended to defray the uncompensated costs of eligible services provided to eligible individuals.

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

(c) Calculating a state payment cap. Using information from each hospital's DSH and UC Application, Medicaid cost reports and from HHSC's Medicaid contractors, HHSC will determine the hospital's state payment cap in compliance with paragraphs (1), (2), (3), and (4) of this subsection. The state payment cap will be used for both DSH and uncompensated care waiver interim payment determinations.

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

(A) Uninsured charges and payments.

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

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

(I) For purposes of this paragraph, a payment received is any payment

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

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

(B) Medicaid charges and payments.

(i) HHSC will request from its Medicaid contractors the inpatient and outpatient charge and payment data for claims for services provided to Medicaid-enrolled individuals that are adjudicated during the data year.

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

(-a-) claims associated with the care of dually eligible patients, including Medicare charges and payments;

(-b-) claims or portions of claims that were not paid because they exceeded the spell-of-illness limitation;

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

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

(II) HHSC will exclude charges and payments for:

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

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

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

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

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

(iii) HHSC will notify hospitals following HHSC's receipt of the requested data from the Medicaid contractors. A hospital's right to request a review of data it believes is incorrect or incomplete is addressed in subsection (e) of this section.

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

adjudicated during the data year.

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

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

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

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

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

(ii) Determining inpatient routine costs.

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

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

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

(iii) Determining inpatient and outpatient ancillary costs.

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

ancillary cost center to determine a Medicaid cost-to-charge ratio for each ancillary cost center.

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

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

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

(2) Calculation of the full-offset payment ceiling.

(A) Total hospital cost. HHSC will sum the total cost for all Medicaid payor types and the uninsured from paragraph (1)(C)(iv) of this section to determine the total hospital cost for Medicaid and the uninsured.

(B) Total hospital payments. HHSC will reduce the total hospital cost under subparagraph (A) of this paragraph by total payments from all payor sources, including graduate medical services and out-of-state payments. HHSC ~~may~~ shall reduce the total hospital cost by supplemental payments or uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributed to the hospital for the program year ~~if necessary~~ to prevent total interim payments to a hospital for the program year from exceeding the state payment cap for that program year.

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

(3) Calculation of the Recoupment Prevention Payment Ceiling.

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

(B) Total hospital payments. HHSC will reduce the total hospital cost under subparagraph (A) of this paragraph by total payments in accordance with Section 1923(g) of the Social Security Act. For example, starting with the program period

beginning October 1, 2022, HHSC will reduce the total hospital cost under subparagraph (A) of this paragraph by the total payments from Medicaid and the uninsured, including graduate medical services and out-of-state payments. HHSC ~~may~~ shall reduce the total hospital cost by supplemental payments or uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributed to the hospital for the program year ~~if necessary~~ to prevent total interim payments to a hospital for the program year from exceeding the state payment cap for that program year.

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

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

(4) State Payment Cap.

(A) For program periods beginning October 1, 2022, HHSC will determine the lesser of between the two payment ceilings described in paragraphs (2) and (3) of this subsection. The lesser of the two payment ceilings will constitute the State Payment Cap for the DSH program described in §355.8065 of this division and in the UC program described in §355.8212 of this subchapter.

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

(C) For program periods beginning on or after October 1, 2017 and ending on or before September 30, 2019, the state payment cap uses the costs in paragraph (2)(A) of this subsection and the payments for inpatient and outpatient claims under Title XIX of the Social Security Act, including graduate medical services and out-of-state payments, and payments on behalf of the uninsured.

(D) For program periods beginning on or after October 1, 2013 and ending on or before September 30, 2017, the state payment cap uses the costs in paragraph (2)(A) of this subsection and the payments from all payor sources, including graduate medical services and out-of-state payments, excluding third-party commercial insurance payors for inpatient and outpatient claims.

(d) Hospital-Specific Limit.

(1) HHSC will calculate the individual components of a hospital's hospital-specific limit using the calculation set out in subsection (c)(3) of this section, except that

HHSC will:

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

(B) include supplemental payments (including upper payment limit payments) and uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributable to the hospital for the program year when calculating the total payments to be subtracted from total costs as described in subsection (c)(3)(A) of this section;

(C) use the hospital's actual charges and payments for services described in subsection (c)(1)(A) and (c)(1)(B) of this section provided to Medicaid-eligible and uninsured patients during the program year; and

(D) include charges and payments for claims submitted after the 95-day filing deadline for Medicaid-allowable services provided during the program year unless such claims were submitted after the Medicare filing deadline.

(2) For payments to a hospital under the DSH program, the hospital-specific limit will be calculated at the time of the independent audit conducted under §355.8065(o) of this division.

(3) Federally authorized exceptions to the Hospital-specific limit (HSL) calculation. A hospital that believes that it qualifies for an exception authorized by Section 1923(g) of the Social Security Act to the calculation described in paragraph (f)(3) of this section may request that HHSC or its contractors calculate the HSL in accordance with the exception authorized by federal law. HHSC will adhere to CMS' determination on eligibility for exception authorized by Section 1923(g) of the Social Security Act whenever available. The following conditions and procedures will apply to all such requests received by HHSC or its contractors.

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

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

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

(e) Due date for DSH and UC Application.

(1) HHSC Provider Finance Department must receive a hospital's completed application no later than 30 calendar days from the date of HHSC's written request

to the hospital for the completion of the application, unless an extension is granted as described in paragraph (2) of this subsection.

(2) HHSC Provider Finance Department will extend this deadline provided that HHSC receives a written request for the extension by email no later than 30 calendar days from the date of the request for the completion of the application.

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

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

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

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

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

(2) Request for review of data.

(A) HHSC will pre-populate certain fields in the DSH and UC Application, including data from its Medicaid contractors.

(i) A hospital may request that HHSC review any data in the hospital's DSH and UC Application that is pre-populated by HHSC.

(ii) A hospital may not request that HHSC review self-reported data included in the DSH and UC Application by the hospital.

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

(3) HHSC's review.

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

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

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

(iii) solely a data review; and

(iv) not an adversarial hearing.

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

(i) If changes to the Medicaid data are made as a result of the review process, HHSC will use the corrected data for the HSL calculations described in this section and for other purposes described in §355.8065 and §355.8212 of this subchapter.

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

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

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

(i) the state payment cap or hospital-specific limit calculated as described in this section, unless it is related to exceptions permitted by Section 1923(g) of the Social Security Act;

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

(iii) uncompensated-care payment amounts calculated as described in §355.8201 or §355.8212 of this subchapter.

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 11 TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT

§355.8212. Waiver Payments to Hospitals for Uncompensated Charity Care.

(a) Introduction. Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver payments are available under this section to help defray the uncompensated cost of charity care provided by eligible hospitals on or after October 1, 2019. Waiver payments to hospitals for uncompensated care provided before October 1, 2019, are described in §355.8201 of this division (relating to Waiver Payments to Hospitals for Uncompensated Care). Waiver payments to hospitals must be in compliance with the Centers for Medicare & Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions, and this section.

(b) Definitions.

(1) Allocation amount--The amount of funds approved by the Centers for Medicare & Medicaid Services for uncompensated-care payments for the demonstration year that is allocated to each uncompensated-care provider pool or individual hospital, as described in subsections (f)(2) and (g)(6) of this section.

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

(3) Charity care--Healthcare services provided without expectation of reimbursement to uninsured patients who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association Principles and Practices Board Statement 15 (December 2012). Charity care includes full or partial discounts given to uninsured patients who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

(4) Data year--A 12-month period that is described in §355.8066 of this subchapter (relating to State Payment Cap and Hospital-Specific Limit Methodology) and from which HHSC will compile cost and payment data to determine uncompensated-care payment amounts. This period corresponds to the Disproportionate Share Hospital data year.

(5) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. This period corresponds to the Disproportionate Share Hospital (DSH) program year. Demonstration year one corresponded to the 2012 DSH program year, October 1, 2011, through September 30, 2012.

(6) Disproportionate Share Hospital (DSH)--A hospital participating in the Texas Medicaid program as defined in §355.8065 of this subchapter (relating to Disproportionate Share Hospital Reimbursement Methodology).

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

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

(9) Impecunious charge ratio--A ratio used to determine if a hospital is eligible to receive payment from the HICH (High Impecunious Charge Hospital) pool as described in subsection (f)(2)(C)(ii) of this section.

(10) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness, defined in §1905(i) of the Social Security Act. IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.8060 of this subchapter (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities) and §355.761 of this chapter (relating to Reimbursement Methodology for Institutions for Mental Diseases (IMD)).

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

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

(13) Mid-Level Professional--Medical practitioners which include the following professions only:

(A) Certified Registered Nurse Anesthetists;

(B) Nurse Practitioners;

(C) Physician Assistants;

(D) Dentists;

(E) Certified Nurse Midwives;

(F) Clinical Social Workers;

(G) Clinical Psychologists; and

(H) Optometrists.

(14) Non-public hospital--A hospital that meets the definition of non-public provider as defined in §355.8200 of this subchapter (relating to Retained Funds for the Uncompensated Care Program).

(15) Public funds--Funds derived from taxes, assessments, levies, investments,

and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

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

(17) Rural hospital--A hospital enrolled as a Medicaid provider that:

(A) is located in a county with ~~60~~68,~~000~~ 750 or fewer persons according to ~~the 2010~~most recent decennial census U.S. Census; or

(B) was designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH) before October 1, 2021; or

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

(D) meets all of the following:

(i) has 100 or fewer beds;

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

(iii) is located in an MSA.

(18) Service Delivery Area (SDA)--The counties included in any HHSC-defined geographic area as applicable to each Managed Care Organization (MCO).

(19) State institution for mental diseases (State IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness defined in §1905(i) of the Social Security Act and that is owned and operated by a state university or other state agency. State IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.761 of this chapter (relating to Reimbursement Methodology for Institutions for Mental Disease (IMD)).

(20) State-owned hospital--A hospital that is defined as a state IMD, state-owned teaching hospital, or a Public Health Hospital (PHH) in this section.

(21) State-owned teaching hospital--A hospital that is a state-owned teaching hospital as defined in §355.8052 of this subchapter (relating to Inpatient Hospital Reimbursement).

(22) State Payment Cap--The maximum payment amount, as applied to payments that will be made for the program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured. The state payment cap is calculated using the methodology described in §355.8066 of this subchapter.

(23) Transferring public hospital--A hospital that is a transferring public hospital as defined in §355.8065 of this subchapter.

(24) Uncompensated-care application--A form prescribed by HHSC to identify uncompensated costs for Medicaid-enrolled providers.

(25) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in this subsection.

(26) Uninsured patient--An individual who has no health insurance or other source of third-party coverage for the services provided. The term includes an individual enrolled in Medicaid who received services that do not meet the definition of medical assistance in section 1905(a) of the Social Security Act (Medicaid services), if such inclusion is specified in the hospital's charity-care policy or financial assistance policy and the patient meets the hospital's policy criteria.

(27) Waiver--The Texas Healthcare Transformation and Quality Improvement Program Medicaid demonstration waiver under §1115 of the Social Security Act.

(c) Eligibility. A hospital that meets the requirements described in this subsection may receive payments under this section.

(1) Generally. To be eligible for any payment under this section:

(A) A hospital must be enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year.

(B) A hospital must meet any criteria described by the waiver as a condition of eligibility to receive an uncompensated-care payment.

(C) Non-public hospitals must not return or reimburse to a governmental entity any part of a payment under this section.

(D) Public Hospitals must be operated by a governmental entity, have that designation filed with HHSC and must not receive, and have no agreement to receive, any portion of the payments made to any non-public hospital.

(E) A non-public provider must have paid the Uncompensated Care (UC) application fee upon submission of the application in accordance with §355.8200 of this subchapter.

(F) Beginning in demonstration year thirteen, all non-rural hospitals, except for state-owned hospitals, will be required to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs, within the State of Texas to participate in UC. This requirement does not apply to a program or component, as applicable, if:

(i) a hospital's estimated payment:

(I) is less than $25,000 from the entire program for a program without

multiple components; or

(II) is less than $25,000 from a component for a program with multiple components; and

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

(2) Uncompensated-care payments. For a hospital to be eligible to receive uncompensated-care payments, in addition to the requirements in paragraph (1) of this subsection, the hospital must submit to HHSC an uncompensated-care application for the demonstration year, as is more fully described in subsection (g)(1) of this section, by the deadline specified by HHSC.

(3) Changes that may affect eligibility for uncompensated-care payments.

(A) If a hospital closes, loses its license, loses its Medicare or Medicaid eligibility, or files bankruptcy before receiving all or a portion of the uncompensated-care payments for a demonstration year, HHSC will determine the hospital's eligibility to receive payments going forward on a case-by-case basis. In making the determination, HHSC will consider multiple factors including whether the hospital was in compliance with all requirements during the demonstration year and whether it can satisfy the requirement to cooperate in the reconciliation process as described in subsection (i) of this section.

(B) A hospital must notify HHSC Provider Finance Department in writing within 30 days of the filing of bankruptcy or of changes in ownership, operation, licensure, or Medicare or Medicaid enrollment that may affect the hospital's continued eligibility for payments under this section.

(C) Merged Hospitals.

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

(I) a hospital that was a party to the merger submits to HHSC documents verifying the merger status with Medicare prior to the deadline for submission of the UC application for that demonstration year; and

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

(ii) If the requirements of clause (i) are not met, HHSC will not consider the merger for purposes of determining eligibility or calculating a hospital's demonstration year payments under this section. Until HHSC determines that the hospitals are eligible for payments as a merged hospital, each of the merging hospitals will continue to receive any UC payments to which they were entitled prior to the merger.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities. Governmental entities that choose to support payments under this section affirm that funds transferred to HHSC meet federal requirements related to the non-federal share of such payments, including §1903(w) of the Social Security Act. Prior to processing uncompensated-care payments for the final payment period within a waiver demonstration year for any uncompensated-care pool or sub-pool described in subsection (f)(2) of this section, HHSC will survey the governmental entities that provide public funds for the hospitals in that pool or sub-pool to determine the amount of funding available to support payments from that pool or sub-pool.

(e) Payment frequency. HHSC will distribute waiver payments on a schedule to be determined by HHSC and posted on HHSC's website.

(f) Funding limitations.

(1) Maximum aggregate amount of provider pool funds. Payments made under this section are limited by the maximum aggregate amount of funds allocated to the provider's uncompensated-care pool for the demonstration year. If payments for uncompensated care for an uncompensated-care pool attributable to a demonstration year are expected to exceed the aggregate amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(6) of this section.

(2) Uncompensated-care pools.

(A) HHSC will designate different pools for demonstration years as follows:

(i) for demonstration years nine and ten, a state-owned hospital pool, a non-state-owned hospital pool, a physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool;

(ii) for demonstration year eleven, a state-owned hospital pool, a non-state-owned hospital pool, a state-owned physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool; and

(iii) for demonstration years twelve and beyond, a state-owned hospital pool, a non-state-owned hospital pool, a high impecunious charge hospital (HICH) pool, a state-owned physician group practice pool, a non-state-owned physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool.

(B) The state-owned hospital pool.

(i) The state-owned hospital pool funds uncompensated-care payments to state-owned hospitals as defined in subsection (b) of this section.

(ii) HHSC will determine the allocation for this pool at an amount less than or equal to the total annual maximum uncompensated-care payment amount for these hospitals as calculated in subsection (g)(2) of this section.

(C) The state-owned physician group practice pool.

(i) Beginning in demonstration year eleven, the state-owned physician group practice pool funds uncompensated-care payments to state-owned physician groups, as defined in §355.8214 of this division (relating to Waiver Payments to Physician Group Practices for Uncompensated Charity Care).

(ii) HHSC will determine the allocation for this pool at an amount less than or equal to the total maximum uncompensated-care payment amount for these physicians.

(D) The High Impecunious Charge Hospital (HICH) pool.

(i) Beginning in demonstration year twelve, the HICH pool funds will be allocated amongst hospitals with a high proportion of uncompensated care charges, rural, and state-owned hospitals. While the funds are set aside before the non-state provider pools, the payments will be calculated for each hospital after both the state-owned hospital pool payments in subparagraph (B) of this paragraph and non-state-owned hospital pool payments in subparagraph (E) of this paragraph.

(ii) A hospital will be deemed as having a high proportion of uncompensated care charges if its impecunious charge ratio is equal to or greater than ~~30~~ 27.5 percent, calculated as follows:

(I) The sum of the charges for DSH uninsured charges and total uninsured charity charges, minus any duplicate uninsured charges is the numerator.

(II) The total allowable hospital revenue is the denominator.

(iii) HHSC will determine the allocation for this pool at an amount less than the difference in the amount of the total allowable UC pool and the amount of the total allowable UC pool in DY11 but equal to a percentage determined by HHSC annually based on certain factors including charity-care costs, the ratio of reported charity-care costs to hospitals' charity-care costs, and the overall financial stability of hospitals of all ownership types and geographic locations as determined by HHSC.

(E) Non-state-owned provider pools. HHSC will allocate the remaining available uncompensated-care funds, if any, among the non-state-owned provider pools as described in this subparagraph. The remaining available uncompensated-care funds equal the amount of funds approved by CMS for uncompensated-care payments for the demonstration year less the sum of funds allocated to the pools under subparagraphs (B)-(D) of this paragraph. HHSC will allocate the funds among non-state-owned provider pools based on the following amounts.

(i) For the physician group practice pool in demonstration years nine and ten, or the non-state-owned physician group practice pool beginning in demonstration year eleven, the governmental ambulance provider pool, and the publicly owned dental provider pool:

(I) for demonstration year nine, an amount to equal the percentage of the applicable total uncompensated-care pool amount paid to each group in demonstration year six; and

(II) for demonstration years ten and after, an amount to equal a percentage determined by HHSC annually based on factors including the amount of reported charity-care costs and the ratio of reported charity-care costs to hospitals' charity-care costs. For physicians, current year charity-care costs will be used, while for dental and ambulance providers, prior year charity-care costs will be used.

(ii) For the non-state-owned hospital pool, all of the remaining funds after the allocations described in clause (i) of this subparagraph. HHSC will further allocate the funds in the non-state-owned hospital pool among all hospitals in the pool and create non-state-owned hospital sub-pools as follows:

(I) calculate a revised maximum payment amount for each non-state-owned hospital as described in subsection (g)(6) of this section and allocate that amount to the hospital; and

(II) group all non-state-owned hospitals and non-state-owned physician groups into sub-pools based on its geographic location within one of the state's Medicaid service delivery areas (SDAs), as described in subsection (g)(7) of this section.

(3) Availability of funds. Payments made under this section are limited by the availability of funds identified in subsection (d) of this section and timely received by HHSC. If sufficient funds are not available for all payments for which the providers in each pool or sub-pool are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(4) Redistribution. If for any reason funds allocated to a provider pool or to individual providers within a sub-pool are not paid to providers in that pool or sub-pool for the demonstration year, the funds will be redistributed to other provider pools based on each pool's pro-rata share of remaining uncompensated costs for the same demonstration year. The redistribution will occur when the reconciliation for that demonstration year is performed.

(g) Uncompensated-care payment amount.

(1) Application.

(A) Cost and payment data reported by a hospital in the uncompensated-care application is used to calculate the annual maximum uncompensated-care payment amount for the applicable demonstration year, as described in paragraph (2) of this subsection.

(B) Unless otherwise instructed in the application, a hospital must base the cost and payment data reported in the application on its applicable as-filed CMS 2552 Cost Report(s) For Electronic Filing Of Hospitals corresponding to the data year and must comply with the application instructions or other guidance issued by

HHSC.

(i) When the application requests data or information outside of the as-filed cost report(s), a hospital must provide all requested documentation to support the reported data or information.

(ii) For a new hospital, the cost and payment data period may differ from the data year, resulting in the eligible uncompensated costs based only on services provided after the hospital's Medicaid enrollment date. HHSC will determine the data period in such situations.

(2) Calculation.

(A) A hospital's annual maximum uncompensated-care payment amount is the sum of the components described in clauses (i) - (iv) of this subparagraph.

(i) The hospital's inpatient and outpatient charity-care costs pre-populated in or reported on the uncompensated-care application, as described in paragraph (3) of this subsection, reduced by interim DSH payments for the same program period, if any, that reimburse the hospital for the same costs. To identify DSH payments that reimburse the hospital for the same costs, HHSC will:

(I) use self-reported information on the application to identify charges that can be claimed by the hospital in both DSH and Uncompensated Care (UC), convert the charges to cost, and reduce the cost by any applicable payments described in paragraph (3) of this subsection;

(II) calculate a DSH-only uninsured shortfall by reducing the hospital's total uninsured costs, calculated as described in §355.8066 of this subchapter, by the result from subclause (I) of this clause; and

(III) reduce the interim DSH payment amount by the sum of:

(-a-) the DSH-only uninsured shortfall calculated as described in subclause (II) of this clause; and

(-b-) the hospital's Medicaid shortfall, calculated as described in §355.8066 of this subchapter.

(ii) Other eligible costs for the data year, as described in paragraph (4) of this subsection.

(iii) Cost and payment adjustments, if any, as described in paragraph (5) of this subsection.

(iv) For each transferring public hospital, the amount transferred to HHSC to that hospital and private hospitals to support DSH payments for the same demonstration year.

(B) A hospital also participating in the DSH program cannot receive total uncompensated-care payments under this section (relating to inpatient and

outpatient hospital services provided to uninsured charity-care individuals) and DSH payments that exceed the hospital's total eligible uncompensated costs. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's state payment cap for interim payments or DSH hospital-specific limit (HSL) in the UC reconciliation plus the unreimbursed costs of inpatient and outpatient services provided to uninsured charity-care patients not included in the state payment cap or HSL for the corresponding program year.

(3) Hospital charity-care costs.

(A) For each hospital required by Medicare to submit schedule S-10 of the Medicaid cost report, HHSC will pre-populate the uncompensated-care application described in paragraph (1) of this subsection with the uninsured charity-care charges and payments reported by the hospital on schedule S-10 for the hospital's cost reporting period ending in the calendar year two years before the demonstration year. For example, for demonstration year 9, which coincides with the federal fiscal year 2020, HHSC will use data from the hospital's cost reporting period ending in the calendar year 2018. Hospitals should also report any additional payments associated with uninsured charity charges that were not captured in worksheet S-10 in the application described in paragraph (1) of this subsection.

(B) For each hospital not required by Medicare to submit schedule S-10 of the Medicaid cost report, the hospital must report its hospital charity-care charges and payments in compliance with the instructions on the uncompensated-care application described in paragraph (1) of this subsection.

(i) The instructions for reporting eligible charity-care costs in the application will be consistent with instructions contained in schedule S-10.

(ii) An IMD may not report charity-care charges for services provided during the data year to patients aged 21 through 64.

(4) Other eligible costs.

(A) In addition to inpatient and outpatient charity-care costs, a hospital may also claim reimbursement under this section for uncompensated charity care, as specified in the uncompensated-care application, that is related to the following services provided to uninsured patients who meet the hospital's charity-care policy:

(i) direct patient-care services of physicians and mid-level professionals; and

(ii) certain pharmacy services.

(B) A payment under this section for the costs described in subparagraph (A) of this paragraph are not considered inpatient or outpatient Medicaid payments for the purpose of the DSH audit described in §355.8065 of this subchapter.

(5) Adjustments. When submitting the uncompensated-care application, a hospital may request that cost and payment data from the data year be adjusted to reflect increases or decreases in costs resulting from changes in operations or

circumstances.

(A) A hospital:

(i) may request that costs not reflected on the as-filed cost report, but which would be incurred for the demonstration year, be included when calculating payment amounts; and

(ii) may request that costs reflected on the as-filed cost report, but which would not be incurred for the demonstration year, be excluded when calculating payment amounts.

(B) Documentation supporting the request must accompany the application, and provide sufficient information for HHSC to verify the link between the changes to the hospital's operations or circumstances and the specified numbers used to calculate the amount of the adjustment.

(i) Such supporting documentation must include:

(I) a detailed description of the specific changes to the hospital's operations or circumstances;

(II) verifiable information from the hospital's general ledger, financial statements, patient accounting records or other relevant sources that support the numbers used to calculate the adjustment; and

(III) if applicable, a copy of any relevant contracts, financial assistance policies, or other policies or procedures that verify the change to the hospital's operations or circumstances.

(ii) HHSC will deny a request if it cannot verify that costs not reflected on the as-filed cost report will be incurred for the demonstration year.

(C) Notwithstanding the availability of adjustments impacting the cost and payment data described in this section, no adjustments to the state payment cap will be considered for purposes of Medicaid DSH payment calculations described in §355.8065 of this subchapter.

(6) Reduction to stay within uncompensated-care pool allocation amounts. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year for any uncompensated-care pool described in subsection (f)(2) of this section, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the pool to exceed the allocation amount for the pool and will reduce the maximum uncompensated-care payment amounts providers in the pool are eligible to receive for that period as required to remain within the pool allocation amount.

(A) Calculations in this paragraph will be applied to each of the uncompensated-care pools separately.

(B) HHSC will calculate the following data points.

(i) For each provider, prior period payments equal prior period uncompensated-care payments for the demonstration year, including advance payments described in paragraph (9) of this subsection, and payments allocated in preceding UC pools. For example, the HICH pool will consider UC payments allocated in the state-owned hospital and non-state-owned hospital pools.

(ii) For each provider, a maximum uncompensated-care payment for the payment period to equal the sum of:

(I) the portion of the annual maximum uncompensated-care payment amount calculated for that provider (as described in this section and the sections referenced in subsection (f)(2) of this section) that is attributable to the payment period; and

(II) the difference, if any, between the portions of the annual maximum uncompensated-care payment amounts attributable to prior periods and the prior period payments calculated in clause (i) of this subparagraph.

(iii) The cumulative maximum payment amount to equal the sum of prior period payments from clause (i) of this subparagraph and the maximum uncompensated-care payment for the payment period from clause (ii) of this subparagraph for all members of the pool combined.

(iv) A pool-wide total maximum uncompensated-care payment for the demonstration year to equal the sum of all pool members' annual maximum uncompensated-care payment amounts for the demonstration year from paragraph (2) of this subsection.

(v) A pool-wide ratio calculated as the pool allocation amount from subsection (f)(2) of this section divided by the pool-wide total maximum uncompensated-care payment amount for the demonstration year from clause (iv) of this subparagraph.

(C) If the cumulative maximum payment amount for the pool from subparagraph (B)(iii) of this paragraph is less than the allocation amount for the pool, each provider in the pool is eligible to receive its maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph without any reduction to remain within the pool allocation amount.

(D) If the cumulative maximum payment amount for the pool from subparagraph (B)(iii) of this paragraph is more than the allocation amount for the pool, HHSC will calculate a revised maximum uncompensated-care payment for the payment period for each provider in the pool as follows.

(i) The physician group practice pool, the governmental ambulance provider pool, and the publicly owned dental provider pool. HHSC will calculate a capped payment amount equal to the product of each provider's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the pool-wide ratio calculated in subparagraph (B)(v) of this paragraph.

(ii) The non-state-owned hospital pool.

(I) For rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all rural hospitals in the pool;

(-b-) in demonstration year:

(-1-) nine and ten, set aside for rural hospitals the amount calculated in item (-a-) of this subclause; or

(-2-) eleven and after, set aside for rural hospitals the lesser of the amount calculated in item (-a-) of this subclause or the amount set aside for rural hospitals in demonstration year ten;

(-c-) calculate a ratio to equal the rural hospital set-aside amount from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(II) For non-rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all non-rural hospitals in the pool;

(-b-) calculate an amount to equal the difference between the pool allocation amount from subsection (f)(2) of this section and the set-aside amount from subclause (I)(-b-) of this clause;

(-c-) calculate a ratio to equal the result from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for non-rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each non-rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(III) The revised maximum uncompensated-care payment for the payment period equals the lesser of:

(-a-) the maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph; or

(-b-) the difference between the capped payment amount from

subclause (I) or (II) of this clause and the prior period payments from subparagraph (B)(i) of this paragraph.

(IV) HHSC will allocate to each non-state-owned hospital the revised maximum uncompensated-care payment amount from subclause (III) of this clause.

(7) Non-state-owned hospital SDA sub-pools. After HHSC completes the calculations described in paragraph (6) of this subsection, HHSC will place each non-state-owned hospital into a sub-pool based on the hospital's geographic location in a designated Medicaid SDA for purposes of the calculations described in subsection (h) of this section.

(8) Prohibition on duplication of costs. Eligible uncompensated-care costs cannot be reported on multiple uncompensated-care applications, including uncompensated-care applications for other programs. Reporting on multiple uncompensated-care applications is a duplication of costs.

(9) Advance payments.

(A) In a demonstration year in which uncompensated-care payments will be delayed pending data submission or for other reasons, HHSC may make advance payments to hospitals that meet the eligibility requirements described in subsection (c)(2) of this section and submitted an acceptable uncompensated-care application for the preceding demonstration year from which HHSC calculated an annual maximum uncompensated-care payment amount for that year.

(B) The amount of the advance payments will:

(i) in demonstration year nine, be based on uninsured charity-care costs reported by the hospital on schedule S-10 of the CMS 2552-10 cost report used for purposes of sizing the UC pool, or on documentation submitted for that purpose by each hospital not required to submit schedule S-10 with its cost report; and

(ii) in demonstration years ten and after, be a percentage, to be determined by HHSC, of the annual maximum uncompensated-care payment amount calculated by HHSC for the preceding demonstration year.

(C) Advance payments are considered to be prior period payments as described in paragraph (6)(B)(i) of this subsection.

(D) A hospital that did not submit an acceptable uncompensated-care application for the preceding demonstration year is not eligible for an advance payment.

(E) If a partial year uncompensated-care application was used to determine the preceding demonstration year's payments, data from that application may be annualized for use in the computation of an advance payment amount.

(h) Payment methodology.

(1) Notice. Prior to making any payment described in subsection (g) of this section, HHSC will give notice of the following information:

(A) the maximum payment amount for each hospital in a pool or sub-pool for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

(B) the maximum IGT amount necessary for hospitals in a pool or sub-pool to receive the amounts described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to hospitals in each pool or sub-pool will be determined based on the amount of funds transferred by governmental entities as follows.

(A) If the governmental entities transfer the maximum amount referenced in paragraph (1) of this subsection, the hospitals in the pool or sub-pool will receive the full payment amount calculated for that payment period.

(B) If the governmental entities do not transfer the maximum amount referenced in paragraph (1) of this subsection, each hospital in the pool or sub-pool will receive a portion of its payment amount for that period, based on the hospital's percentage of the total payment amounts for all providers in the pool or sub-pool.

(3) Final payment opportunity. Within payments described in this section, governmental entities that do not transfer the maximum IGT amount described in paragraph (1) of this subsection during a demonstration year will be allowed to fund the remaining payments to hospitals in the pool or sub-pool at the time of the final payment for that demonstration year. The IGT will be applied in the following order:

(A) to the final payments up to the maximum amount; and

(B) to remaining balances for prior payment periods in the demonstration year.

(i) Reconciliation. HHSC will reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments, if any, made to the hospital for the same period.

(1) If a hospital received payments in excess of its actual costs, the overpaid amount will be recouped from the hospital, as described in subsection (j) of this section.

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

(3) Each hospital that received an uncompensated-care payment during a

demonstration year must cooperate in the reconciliation process by reporting its actual costs and payments for that period on the form provided by HHSC for that purpose, even if the hospital closed or withdrew from participation in the uncompensated-care program. If a hospital fails to cooperate in the reconciliation process, HHSC may recoup the full amount of uncompensated-care payments to the hospital for the period at issue.

(j) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a hospital's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the hospital will be returned to the governmental entities in proportion to each entity's initial contribution to funding the program for that hospital's SDA in the applicable program year.

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

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

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

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