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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Center for Medicaid, CHIP, and Survey & Certification**

Mr. Billy Millwee
Associate Commissioner for Medicaid & CHIP
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

DEC - 8 2010

RE: TN 09-34

Dear Mr. Millwee:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-34. This amendment addresses the eligibility of certain large urban hospitals for the urban hospital Upper Payment Limit (UPL) supplemental payment program. The amendment lists new conditions of participation and clarifies the methodology the Health and Human Services Commission (HHSC) uses to compute Medicaid supplemental payments for large urban hospitals. Specifically, language is being added to make five public hospitals in counties with populations greater than 100,000 eligible for supplemental payments, in addition to the eleven large urban hospitals already receiving supplemental payments.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A. Based upon your assurances, Medicaid State plan amendment 09-34 is approved effective September 1, 2009. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Sandra Dasheiff, CPA at (214) 767-6490.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

Enclosures

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

FORM APPROVED
OMB NO. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**
**FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: **09-034**
2. STATE: **TEXAS**
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **September 1, 2009**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
**Section 1902(a)(30)(A) of the Act**
**42 C.F.R. §§ 447.271, 447.272, 447.321, 447.325**

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2009** **$0**
b. FFY **2010** **$0**
c. FFY **2011** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
**SEE ATTACHMENT**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
**SEE ATTACHMENT**

10. SUBJECT OF AMENDMENT:

**The proposed amendment addresses the eligibility of certain large urban hospitals for the urban hospital UPL supplemental payment program. The amendment lists new conditions of participation and clarifies the methodology HHSC uses to compute Medicaid supplemental payments for large urban hospitals. Specifically, language is being added to make six public hospitals in counties with populations greater than 100,000 eligible for supplemental payments, in addition to the 11 large urban hospitals already receiving supplemental payments.**

11. GOVERNOR'S REVIEW *(Check One)*:

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
**Chris Traylor**

14. TITLE:
**State Medicaid Director**

15. DATE SUBMITTED:
**September 25, 2009**

16. RETURN TO:
**Chris Traylor**
**State Medicaid Director**
**Post Office Box 85200**
**Austin, Texas 78711-5200**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: 12-08-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
SEP - 1 2009

20. [redacted]

21. TYPED NAME:
William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

FORM CMS – 179 (07-92)

**(t) Inpatient Supplemental Payments to Hospitals**

(1) Calculation of the Medicaid Upper Payment Limit (UPL). The inpatient supplemental payments described in subsections (u) - (z) will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 Code of Federal Regulations (CFR) § 447.272. The following method is used to reasonably estimate the Medicaid upper limit. The Medicare Standardized Amount is multiplied by the Medicaid Case Mix derived using Medicare Relative Weights to yield the Medicare DRG Reimbursement for Medicaid Claims. Medicare Pass-Through Payments is divided by Medicaid Discharges to yield Medicare Pass-Through Payments per Discharge. The Medicare DRG Reimbursement for Medicaid Claims is added to Medicare Pass-Through Payments per Discharge to yield the Medicare Equivalent Reimbursement per Discharge per Hospital. This Medicare Equivalent Reimbursement per Discharge per Hospital is multiplied by Medicaid Discharges to yield the Medicaid UPL per Hospital.

(2) Definitions. When used in subsections (u) - (z), the following terms have the following meanings, unless the context clearly indicates otherwise.

(A) Adjudicated Medicaid Claim—A hospital claim for payment for a covered Medicaid service that is paid or adjusted by HHSC or another payer.
(B) Disproportionate Share Hospital (DSH)—Hospitals participating in the Texas Medical Assistance (Medicaid) program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for additional reimbursement from the DSH fund.
(C) DSH Limit—DSH Limit has the meaning assigned to the term "hospital specific limit," as determined under Appendix 1 to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals).
(D) Publicly-Owned or -Affiliated Hospital—A hospital owned by or affiliated with a city, county, hospital authority or hospital district.

(3) The supplemental payments authorized for all hospitals identified in subsections (u) and (z) are subject to the following limits:

(A) For Disproportionate Share Hospitals (DSH), in each fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments will not exceed the hospital's DSH Limit, as determined under Appendix 1 to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals); and

**(u) Supplemental Payments to Certain Urban Hospitals**

(1) Introduction. Supplemental payments are available under this section for inpatient hospital services provided by eligible publicly-owned or -affiliated urban hospitals that serve high volumes of Medicaid and uninsured patients.

(2) Eligible hospitals. Supplemental payments are available under this section for inpatient hospital services provided by publicly-owned hospitals in Bexar, Brazoria, Dallas, Ector, El Paso, Fort Bend, Harris, Lubbock, Nueces, Midland, Tarrant, Travis, and Wichita counties; and a hospital located in Potter County that is affiliated with the Amarillo Hospital District. The publicly-owned or -affiliated hospital or hospitals in each listed county that incur the greatest cost(s) for providing services to Medicaid and uninsured patients will be eligible to receive supplemental payments. No more than two hospitals in any county will be eligible.

(3) Dates of eligibility. Supplemental payments will be made for inpatient services on or after July 6, 2001, for hospitals in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis counties. Supplemental payments will be made for inpatient services on or after February 7, 2004, for hospitals in Midland County. Supplemental payments will be made for inpatient services on or after May 29, 2004, for a hospital in Potter County affiliated with the Amarillo Hospital District. Supplemental payments will be made for inpatient services provided on or after September 1, 2009, for hospitals in Brazoria, Fort Bend, and Wichita counties, as well as any hospital in Dallas County or Harris County that was not eligible as of February 7, 2004, subject to the limits in paragraph (3) of this subsection (u).

**(z) Supplemental Payments to Private Hospitals.**

(1) Introduction. Private Hospitals with an indigent care affiliation agreement with a hospital district or other local government entity and that serve high volumes of Medicaid and uninsured patients shall be considered eligible to receive supplemental payments under this section.

(2) Eligible Hospitals. Supplemental payments will be made for inpatient services on or after June 11, 2005, for eligible private hospitals in Hidalgo, Maverick, Montgomery, Travis, Bexar, and Webb Counties. Supplemental payments will be made for inpatient services on or after November 12, 2005, for all other eligible private hospitals.

**4. Outpatient Hospital Reimbursement**

(a) Medicaid payments for outpatient hospital services are equal to a percentage of full, allowable costs and are determined in the following manner:

(1) Interim Medicaid payments are paid for a hospital's allowable Medicaid Outpatient claim based on the following calculation:

(A) The allowable Medicaid Outpatient charges per claim are multiplied by the cost reduction percentage, described in (C) below:

(B) the results in (A) are multiplied by each hospital's ratio of cost to charges as derived from outpatient cost centers contained in the most recently filed Medicaid Hospital Cost Report (CMS Form 3552). This result is the Medicaid Outpatient Hospital Services claim interim payment.

(C) For services delivered on or after September 1, 2001, the cost reduction percentage is equal to 84.48 percent of allowable charges for a high-volume provider, and 80.3 percent allowable charges for the remaining hospitals. A high-volume provider is defined as one that is paid at least $200,000 during calendar year 2004.

(2) Final Medicaid payment is determined by comparing allowed costs to interim payments. The State identifies the allowable costs from outpatient cost centers contained in the hospital fiscal year-end Medicaid Hospital Cost Report as filed on CMS Form 2552. These costs are reduced by the cost reduction factor, described in (C) above, and compared to the aggregate adjudicated interim Medicaid payments for claims with dates of service that match the corresponding hospital fiscal year-end cost report. This comparison will result in a payment or recoupment to/from the hospital provider, also described as an estimate of the total Medicaid outpatient hospital services costs for each provider. The most recent ratio of cost to charges from the cost report settlement process is applied to the future interim Medicaid payment in (4)(a)(1) above and is completed on each "as filed," amended, or Medicare-audited cost report. This methodology results in an estimate of total Medicaid outpatient hospital services cost for each provider that is consistent with the upper payment limit for such services described at 42 CFR 447.321. The methodology described in this section is applicable to provider-based facilities as defined at 42 CFR 413.65.

(b) Hospital Ambulatory Surgical Centers (HASC) are reimbursed in accordance with Attachment 4.19-B, page 7(f), relating to the reimbursement methodology for Ambulatory Surgical Centers (ASCs).

**8. Outpatient Supplemental Payments to Hospitals**

(a) The supplemental payments described in this section (8) will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 C.F.R. §447.321.

(b) Definitions. When used in this section, the following terms have the following meanings, unless the context clearly indicates otherwise.

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

(2) Disproportionate Share Hospital (DSH)—Hospitals participating in the Texas Medical Assistance (Medicaid) program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for additional reimbursement from the DSH fund.

(3) DSH Limit—DSH Limit has the meaning assigned to the term "hospital specific limit," as determined under Appendix 1 to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals) for DSH Hospitals.

(4) Medicaid Allowable Outpatient Hospital Costs—Costs remaining when total billed outpatient hospital charges are reduced by a hospital outpatient reduction factor in accordance with subsection 4(a) of Attachment 4.19-B (relating to Outpatient Hospital Reimbursement).

(5) Publicly-Owned or –Affiliated Hospital—A hospital owned by or affiliated with a city, county, hospital authority or hospital district.

(c) Supplemental Payment Limits

(1) The supplemental payments authorized for all hospitals identified in subsections 8(e) and 8(f) are subject to the following limits:

(i) For Disproportionate Share Hospitals (DSH), in each fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments may not exceed the hospital's DSH Limit, as determined under Appendix 1 to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals) for DSH hospitals;

(ii) For all eligible hospitals, the amount of outpatient supplemental payments and fee-for-service Medicaid outpatient payments the hospital receives in a fiscal year may not exceed Medicaid billed charges for outpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.325.

(2) For all hospitals identified in subsections 8(g) and 8(h), the amount of outpatient supplemental payments and fee-for-service Medicaid outpatient payments the hospital receives in a fiscal year may not exceed Medicaid billed charges for outpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.325.

(d) An eligible hospital under sections (8)(e), (8)(f), and (8)(h) will receive quarterly supplemental payments. The quarterly payments will be the difference between a hospital's fee-for-service payments for adjudicated outpatient Medicaid claims during the calculation period and 100% of Medicaid allowable outpatient hospital cost for those claims.

(e) Outpatient Supplemental Payments to Certain Urban Hospitals

(1) Introduction. Supplemental payments are available under this section (e) for outpatient hospital services provided by eligible publicly-owned or -affiliated urban hospitals that serve high volumes of Medicaid and uninsured patients.

(2) Eligible hospitals. Supplemental payments are available under this subsection (e) for outpatient hospital services provided by publicly-owned hospitals in Bexar, Brazoria, Dallas, Ector, El Paso, Fort Bend, Harris, Lubbock, Nueces, Midland, Tarrant, Travis, and Wichita counties; and a hospital located in Potter County that is affiliated with the Amarillo Hospital District. The publicly-owned or -affiliated hospital or hospitals in each listed county that incur the greatest cost(s) for providing services to Medicaid and uninsured patients may be eligible to receive supplemental payments. No more than two hospitals in any county may be eligible.

(3) Dates of eligibility. Supplemental payments will be made for outpatient services on or after July 6, 2001, for hospitals in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis counties. Supplemental payments will be made for outpatient services on or after June 11, 2005, for hospitals in Midland County and a hospital in Potter County affiliated with the Amarillo Hospital District. Supplemental payments will be made for outpatient services provided on or after September 1, 2009, for hospitals in Brazoria, Fort Bend, and Wichita counties, as well as any hospital in Dallas County or Harris County that was not eligible as of February 7, 2004.

(f) Outpatient Supplemental Payments to Private Hospitals

(1) Introduction. Supplemental payments are available under this subsection (f) for outpatient hospital services provided by eligible private hospitals that serve Medicaid and uninsured patients.

(2) Eligible Hospitals. Supplemental payments will be made for outpatient services on or after June 11, 2005 for eligible private hospitals in Hidalgo, Maverick, Montgomery, Travis, Bexar, and Webb Counties. Supplemental payments will be made for outpatient services on or after November 12, 2005 for all other eligible private hospitals.

(g) Outpatient Supplemental Payments to State-Owned Hospitals

(1) Introduction. Supplemental payments will be made each fiscal year in accordance with this subsection (g) to state government-owned or operated hospitals for services provided to Medicaid patients.

(2) Eligible Hospitals. Supplemental payments are available under this subsection (g) for outpatient hospital services provided by state government-owned or operated hospitals. To qualify for a supplemental payment, the hospital must be owned or operated by the state of Texas.

(3) The amount of the supplemental payment made to each state government owned or operated hospital is the difference between the Medicaid fee-for-service outpatient payments received and 100% of the hospital's Medicaid allowable outpatient hospital cost. Medicaid payments and cost will be based on the most recent complete fiscal year period of fee-for-service adjudicated claims data.

(h) Outpatient Supplemental Payments to Rural Public Hospitals

(1) Introduction. Supplemental payments are available under this subsection (h) for outpatient hospital services provided by eligible rural public hospitals that serve of Medicaid and uninsured patients.

(2) Eligible Hospitals. Supplemental payments are available under this subsection (g) for outpatient hospital services provided by rural public hospitals located in a county of less than 100,000 population based on the most recent federal decennial census.

(B) For all eligible hospitals, the amount of inpatient supplemental payments and fee-for-service Medicaid inpatient payments the hospital receives in a fiscal year will not exceed Medicaid inpatient billed charges for inpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 Code of Federal Regulations (CFR) § 447.271.

(4) An eligible hospital under section (u) or (z) will receive quarterly supplemental payments. The quarterly payments will be:

(A) For Non-DSH Hospitals, the difference between a hospital's fee-for-service billed charges for adjudicated inpatient Medicaid claims and all Medicaid and other payments received during the calculation period for such claims.

(B) For DSH Hospitals, the lesser of:

(i) The difference between a hospital's fee-for-service billed charges for adjudicated inpatient Medicaid claims and all Medicaid and other payments received during the calculation period for such claims; or

(ii) One fourth of the difference between the hospital's DSH Limit and the hospital's DSH payments for the federal fiscal year.

(5) At the time the 4th quarter payment is made for a given federal fiscal year, an eligible hospital under section (u) or (z) may be paid any unfunded supplemental payment for which they were eligible to receive from the first 3 quarters of the federal fiscal year.