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

FEB - 2 2011

RE: TN 10-69

Dear Mr. Millwee:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-69. This amendment rebases payment division standard dollar amount (PDSDA) payments and implements a transitional PDSDA to mitigate the impact of rebasing hospital PDSDA payments from November 1, 2010 through August 31, 2011. This amendment also implements a rebased PDSDA effective September 1, 2011 that eliminates the transitional adjustments.

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 10-69 is approved effective November 1, 2010. 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, CMCS

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: 10-069	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: November 1, 2010	

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:	7. FEDERAL BUDGET IMPACT:	SEE ATTACHMENT
42 CFR §440.10	a. FFY 2011	$ 0
	b. FFY 2012	$ 0
	c. FFY 2013	$ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT TO BLOCKS 8 & 9	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: SEE ATTACHMENT TO BLOCKS 8 & 9	

10. SUBJECT OF AMENDMENT:

The amendment rebases standard dollar amount (SDA) payments and implements a transitional SDA to mitigate the impact of rebasing hospital SDA payments from November 1, 2010 through August 31, 2011. The amendment also implements a rebased SDA effective September 1, 2011 that eliminates the transitional adjustments.

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]	16. RETURN TO:
13. TYPED NAME: **Billy R. Millwee**	**Billy R. Millwee** **State Medicaid Director** **Post Office Box 13247 MC: H-100** **Austin, Texas 78711-5200**
14. TITLE: **State Medicaid Director**	
15. DATE SUBMITTED: **December 22, 2010**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 23 Dec, 2010	18. DATE APPROVED: 02-02-11
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: NOV - 1 2010	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 & 9 to CMS Form 179

Transmittal No. 10-069, Amendment 942

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Attachment 4.19-A	Attachment 4.19-A
Page 1a	Page 1a (TN 97-010)
Page 2	Page 2 (TN 97-010)
Page 3	Page 3 (TN 09-026)
N/A – Delete Page	Page 3a (TN 10-048)
N/A – Delete Page	Page 3b (TN 09-026)
N/A – Delete Page	Page 3c (TN 09-026)
N/A – Delete Page	Page 3d (TN 09-026)
Page 4	Page 4 (TN 97-010)
Page 5	Page 5 (TN 07-021)
Page 6	Page 6 (TN 97-010)
Page 7	Page 7 (TN 97-010)
Page 8	Page 8 (TN 07-021)
Page 8a	N/A – New Page
Page 8b	N/A – New Page
Page 8c	N/A – New Page
Page 8d	N/A – New Page
Page 8e	N/A – New Page
Page 8f	N/A – New Page
Page 8g	N/A – New Page
Page 8h	N/A – New Page
Page 8i	N/A – New Page
Page 8j	N/A – New Page
Page 8k	N/A – New Page
Page 8l	N/A – New Page
Page 9	Page 9 (TN 97-010)
Page 9a	Page 9a (TN 08-024)
Page 9b	Page 9b (TN 08-024)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(a) Application and general reimbursement method.

(1) Covered inpatient hospital services are reimbursed in accordance with the Texas-based diagnosis related group (DRG) prospective payment system methodology, unless otherwise described in the exceptions in subsection (b).

(2) The prospective payment system described in this section applies to inpatient hospital payments for admissions beginning November 1, 2010.

(3) HHSC calculates reimbursement for a covered inpatient hospital service, determined in subsection (g), by multiplying the hospital's payment division standard dollar amount or final standard dollar amount, determined in subsection (d), by the relative weight for the appropriate DRG, determined in subsection (e).

(4) HHSC will rebase hospital-specific and payment division standard dollar amounts during the state fiscal year that is three years after the last rebasing year.

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

(1) In-state and out-of-state children's hospitals. In-state and out-of-state children's hospitals are reimbursed using the methodology described in subsections (j)-(k) of this section.

(2) State-owned teaching hospitals. State-owned teaching hospitals are reimbursed in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) principles using the methodology described in subsection (l) of this section.

(3) Freestanding psychiatric hospitals. Freestanding psychiatric hospitals are reimbursed under the methodology described in subsection (y) of this section.

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

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

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

(2) Average base year cost per claim – One factor used in arriving at the hospital-specific standard dollar amount; the arithmetic mean of base year costs per claim for a hospital, obtained by dividing the sum of all base year costs per claim for that hospital by the number of base year claims in the set.

(3) Base year – A period of 12 consecutive months selected by HHSC.

(4) Base year claims – All Medicaid inpatient hospital claims for reimbursement filed by a hospital that:

(A) Have a date of admission occurring within the base year;

(B) Are adjudicated and approved for payment during the base year and the six-month grace period that immediately follows the base year or another grace period designated by HHSC and communicated in writing to all hospitals, except for such claims that have zero inpatient days;

(C) Are not claims for patients who are covered by Medicare; and

(D) Are not Medicaid spend-down claims.

(5) Base year cost per claim – One factor used in arriving at the hospital-specific standard dollar amount; the cost for a claim that would have been made to a hospital if HHSC reimbursed the hospital under methods and procedures used in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), without the application of the TEFRA Target Cap as described in subsection (d)(10).

(6) Case mix index – The average relative weight of a hospital's base year claims, obtained by summing the hospital's relative weights for all base year claims divided by the total number of that hospital's base year claims.

(7) Cost-of-living Index – An adjustment applied to hospital-specific standard dollar amounts based on the market basket index to account for changes in cost of living.

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

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

(c) Definitions (continued)

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

(10) Data entry error – An error resulting from miskeyed or mistyped data that is different from the intended entry. This type of error does not include the omission of claims approved for payment after the base year and grace period.

(11) Day outlier threshold – One factor used in determining the day outlier payment adjustment.

(12) Day outlier payment adjustment – A payment adjustment for a claim with and extended length of stay.

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

(14) Final settlement – Reconciliation of cost in the Medicare/Medicaid hospital fiscal year end cost report performed by HHSC within six months after HHSC receives the cost report audited by a Medicare intermediary, or in the case of children's hospitals, audited by HHSC.

(15) Final standard dollar amount (SDA) – The payment division standard amount or other rate assigned to a hospital after application of all of the PDSDA adjustments described in (d).

(16) HHSC – The Texas Health and Human Services Commission or its designee.

(17) Hospital-specific standard dollar amount (HSDA) – One factor used in arriving at the PDSDA; the average base year cost per claim for a hospital, adjusted by the case mix index and cost-of-living index.

(18) In-state children's hospital – A hospital located within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(19) Interim payment – An initial payment made to a hospital that is later settled to Medicaid-allowable costs, for hospitals reimbursed under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

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(C) If a payment division has fewer than 20 total base year claims, HHSC considers that payment division to be invalid. Hospitals within that payment division are assigned a PDSDA equal to the mathematically closest valid PDSDA.

(D) Minimum PDSDA. The minimum PDSDA of $1,600.00 is applied to any hospital with an HSDA equal to or less than $1,600.00.

(2) Payment Division Index (PDI).

(A) After all hospitals have been assigned a payment division number, HHSC may adjust the standard dollar amount for that payment division. The resulting PDSDA is the reimbursement rate for all hospitals assigned that payment division number. The PDI is the list of all payment division numbers and the corresponding valid PDSDAs.

(B) If the resulting PDSDA is less than $1,600.00, the minimum PDSDA is applied.

(C) HHSC will assign a payment division designation to the universal mean (average base year cost per claim for all hospitals) plus the cost-of-living update used in the most recent rebasing calculation and will apply any adjustments under subparagraph (A) of this paragraph. The resulting amount is the PDSDA for the payment division assigned to hospitals listed in paragraph (3)(A) of this subsection.

(D) HHSC will assign a payment division designation to be used for a new hospital reimbursement rate. HHSC will calculate the rate as described in paragraph (3)(B) of this subsection and will apply any adjustments under subparagraph (A) of this paragraph, which will be the PDSDA for this designation.

(E) The reimbursement for services effective September 1, 2010, will be equal to the payment that would have been made August 31, 2010, less 1 percent.

(3) PDSDAs for specific types of hospitals:

(A) The following types of hospitals are assigned the PDSDA described in (2)(C):

(i) military hospitals;
(ii) out-of-state hospitals; and
(iii) newly enrolled hospitals.

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(B) New Hospitals.

(i) For a new hospital, HHSC will locate the universal mean in an array of all hospitals' base year costs per claim from lowest to highest. HHSC will then determine the group of claims located within three percentile points above the universal mean. The new hospital is assigned the lowest dollar value claim within that percentile group, plus the cost-of-living update calculated at the most recent rebasing as its PDSDA.

(ii) This rate is effective for five years from the date the rate became effective or until HHSC recalculates PDSDAs, whichever is earlier. After five years from the date HHSC applied the rate determined under clause (i) of this subparagraph, HHSC will assign the hospital the PDSDA described in subparagraph (A) of this paragraph if HHSC has not recalculated PDSDAs.

(iii) A replacement facility constructed for a hospital that is currently enrolled as a Medicaid provider is reimbursed using either the PDSDA of the existing provider or the PDSDA for new hospitals, whichever is greater.

(4) Merged hospitals.

(A) Notice. When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to HHSC's provider enrollment contact, including documents verifying the merger status with Medicare. HHSC will assign to the merged entity a PDSDA, including adjustments, determined using a methodology described in subparagraph (B) of this paragraph for all hospitals involved in the merger.

(B) Determining a merged entity's PDSDA. HHSC will use the following process to determine a merged entity's PDSDA:

(i) When HHSC recognizes a merged entity after HHSC has completed a rebasing in which each of the merging hospitals had been a participating provider and after which none of the merging hospitals were a replacement facility receiving the new-hospital rate as referenced in paragraph (c)(3)(B) of this subsection, HHSC will determine the merged entity's PDSDA as follows:

(I) HHSC will calculate a new HSDA for the entity by combining the original base year cost per claim determined in paragraph (c) of this subsection from the rebasing period for all hospitals involved in the merger;

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(II) Using the resulting HSDA, HHSC will assign the merged entity to a payment division as described in paragraph (2) of this subsection. HHSC will reimburse the merged entity at the PDSDA corresponding to that payment division number within the PDI described in paragraph (2) of this subsection.

(III) HHSC will apply the resulting PDSDA to the surviving and terminated entities' Texas provider numbers retroactive to the date on which Medicare recognized the merged participating provider; and

(IV) HHSC will notify the merged entity of the PDSDA and the effective and termination dates of the Texas provider numbers for the involved hospitals.

(ii) When HHSC recognizes a merged entity involving at least one hospital having a PDSDA that is not based on the average base year cost per claim for that hospital, HHSC will assign the merged entity's PDSDA using the methodology in clause (iii) of this subparagraph. Hospitals in this category may include:

(I) New hospitals;

(II) Newly enrolled hospitals;

(III) Hospitals assigned the new-hospital PDSDA based on construction of a replacement facility.

(iii) When HHSC recognizes a merged entity described in clause (ii), HHSC will determine the merged entity's PDSDA as follows:

(I) For each merging hospital, multiply the hospital's pre-merger PDSDA by the hospital's total number of claims from the claims file for the state fiscal year preceding the Medicare effective date of the merger;

(II) Sum the results of subclause (I) for all merging hospitals;

(III) Divide the result of subclause (II) by the total number of claims for all merging hospitals;

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(IV) HHSC will assign the hospital to the payment division within the PDI that corresponds to the result of the calculation in subclause (III);

(V) HHSC will apply the resulting PDSDA to the surviving and terminated entities' Texas provider numbers retroactive to the date on which Medicare recognized the merged participating provider; and

(VI) HHSC will notify the merged entity of the PDSDA and the effective and termination dates of the Texas provider numbers for the involved hospitals.

(iv) When HHSC recognizes a merged entity during a rebasing in which each of the merging hospitals had been a participating provider:

(I) HHSC will calculate a new HSDA by combining the amounts determined in paragraph (c) of this subsection for all hospitals involved in the merger;

(II) Using the resulting HSDA, HHSC will assign a PDSDA for the merged entity as described for all other hospitals in this subsection;

(III) For any concurrent or retroactive reimbursements prior to the effective date of a rebasing, HHSC will assign the merged entity's PDSDA determined using either the methodology described in clause (i) or (iii).

(C) HHSC will not recalculate the PDSDA of a hospital acquired in an acquisition or buyout unless the acquisition or buyout resulted in the purchased or acquired hospital becoming part of another Medicaid participating provider. HHSC will continue to reimburse the acquired hospital based on the PDSDA applied before the acquisition or buyout.

(5) When the state agency or its designee determines that the state agency or its designee has made an error that, if corrected, would result in the standard dollar amount of the provider for which the error was made changing to a new payment division, either higher or lower, the state agency or its designee moves the provider into the correct payment division, and the

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

(c) Definitions (continued)

(20) Interim rate – The ratio of Medicaid allowed inpatient costs to Medicaid allowed inpatient charges filed on a hospital's Medicare/Medicaid cost report, expressed as a percentage. The interim rate established during a cost report settlement for a DRG reimbursed hospital reimbursed under this section excludes the application of TEFRA Target Caps and the resulting incentive and penalty payments for a hospital's fiscal years ending on or after October 1, 2007.

(21) Market basket index – The Centers for Medicare & Medicaid Services (CMS) projection of the annual percentage increase in hospital inpatient operating costs, as defined in 42 CFR §413.40.

(22) Mathematical error – An error that results from the erroneous application of variables, quotients, or functions within a methodology formula resulting in a different result than intended methodology results. This type of error does not include the omission of claims approved for payment after the base year and grace period.

(23) Mean length of stay (MLOS) – One factor used in determining the payment amount calculated for each diagnosis related group; for each diagnosis related group, the average number of days that a patient stays in the hospital.

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

(25) New hospital – A hospital that was newly constructed and enrolled as a Medicaid provider after the end of the base year.

(26) Newly enrolled hospital – A hospital that was assigned a new Texas Provider Identification number (TPI) and was enrolled as a Medicaid provider after the end of the base year.

(27) Out-of-state children's hospital – A hospital located outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(28) Payment division – A group of hospitals whose calculated hospital-specific standard dollar amounts fall within a $100 range, where the $100 increments begin at zero.

(29) Payment division index (PDI) – A list of all payment divisions and their corresponding valid payment division standard dollar amounts.

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

(c) Definitions (continued)

(30) Payment division standard dollar amount (PDSDA) – The weighted average dollar amount per claim calculated for all hospitals in a payment division.

(31) Rebasing – Calculation of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) cost for base year claims for each Medicaid inpatient hospital. The TEFRA costs for base year claims will be used to recalculate HSDAs, PDSDAs, and DRG statistics (e.g.,relative weight, mean length of stay, and day outlier threshold) using the methods described in this section.

(32) Relative weight – The weighting factor HHSC assigns to a diagnosis related group representing the time and resources associated with providing services for that diagnosis related group.

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

(34) TEFRA cost for rebasing – One factor used in arriving at the hospital-specific standard dollar amount; Medicaid allowable charges for base year claims adjusted to cost by the interim rate derived from tentative or final settlement of cost reports that cover time periods in the base year, or prior period, if a base year cost report is not available.

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

(36) Tentative settlement – Reconciliation of cost in the Medicare/Medicaid hospital fiscal year-end cost report performed by HHSC within six months after HHSC receives an acceptable cost report filed by a hospital.

(37) Universal mean – Average base year cost per claim for all hospitals.

(38) Weighted hospital-specific standard dollar amount (HSDA) – One factor used in arriving at the payment division standard dollar amount; the product obtained by multiplying a hospital's hospital-specific standard dollar amount by the number of its base year claims.

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

(d) Payment Division Standard Dollar Amount (PDSDA).

(1) Rebasing PDSDAs. HHSC may recalculate a hospital's PDSDA using base year claims. HHSC will not include claims that are adjudicated and approved for payment after the base year and subsequent six-month grace period. The six-month grace period is intended to allow HHSC to include as many base year claims as possible, given practical time constraints.

(2) Adjustment of PDSDAs.

(A) HHSC will adjust a hospital's PDSDA pro rata among hospitals to the available funds PDSDA of 62.32 percent of the full cost rebased PDSDA and using one or more of the methods described in (d)(12).

(B) For a hospital that was inactive for reimbursement purposes during any period in which HHSC made an adjustment:

(i) HHSC will adjust the hospital's PDSDA accordingly; and
(ii) HHSC will assign the hospital to a payment division within the PDI that corresponds to the PDSDA as determined in clause (i) of this subparagraph; or
(iii) HHSC will assign the hospital a final SDA if adjustments are made to the hospital's PDSDA under (d)(12).

(C) In addition to the adjustment described in (d)(1), the reimbursement rates for services effective November 1, 2010, will be reduced by an additional 1 percent.

(3) Hospital-specific standard dollar amount (HSDA). Using base year claims, HHSC calculates an HSDA for each hospital as follows:

(A) Determines the base year cost per claim;

(B) Sums the dollar amount for each hospital's base year costs per claim determined in (A);

(C) Calculates the average base year cost per claim by dividing the result in (B) by the total number of base year claims for the hospital;

(D) Calculates the case mix index by summing the hospital's relative weights for all base year claims divided by the total number of that hospital's base year claims;

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

(d) Payment Division Standard Dollar Amount (PDSDA) (continued)

(E) Divides the average base year cost per claim determined in (C) by the hospital's case mix index determined in (D); and

(F) Multiplies the result in (E) by the cost-of-living index described in (d)(4) to adjust costs from the base year to the rate year, which results in the HSDA.

(4) Cost-of-Living Index. HHSC updates HSDAs by applying a cost-of-living index to the HSDA established for the base year. HHSC uses the CMS prospective payment system hospital market basket index based on a federal fiscal year adjusted to a state fiscal year.

(5) Payment Divisions. HHSC groups hospital HSDAs into payment divisions by $100 increments beginning at zero. For example, all hospitals with HSDAs between $1,600.00 and $1,699.99 are grouped together.

(6) Payment Division Standard Dollar Amount (PDSDA).

(A) HHSC computes a PDSDA for all hospitals within a payment division as follows:

(i) multiplies each hospital's HSDA by the hospital's total number of base year claims, resulting in a weighted HSDA;
(ii) sums the weighted HSDAs determined in (i) for all hospitals within a payment division; and
(iii) divides the result in (ii) by the total number of base year claims for all hospitals within a payment division, which results in the PDSDA.

(B) The PDSDA calculation does not include data from the following types of hospitals:

(i) out-of-state hospitals;
(ii) military hospitals;
(iii) new or newly enrolled hospitals;
(iv) in-state and out-of-state children's hospitals;
(v) inpatient psychiatric hospitals; and
(vi) state-owned teaching hospitals.

(C) If a payment division has fewer than 20 total base year claims, HHSC considers that payment division to be statistically invalid. Hospitals within that payment division are assigned a PDSDA equal to the mathematically closest valid PDSDA.

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

(d) Payment Division Standard Dollar Amount (PDSDA) (continued)

(7) Payment Division Index (PDI).

(A) After all hospitals have been assigned a payment division, HHSC will adjust the standard dollar amount for that payment division in accordance with (d)(12). The resulting PDSDA is the reimbursement rate for all hospitals assigned that payment division, unless a hospital in that payment division is assigned a final standard dollar amount as a result of additional adjustments described in (d)(12). The PDI is the list of all payment division numbers and the corresponding valid PDSDAs.

(B) If the resulting PDSDA is less than $1,600.00, the minimum PDSDA of $1,600.00 is applied.

(C) HHSC will assign a payment division designation to the universal mean plus the cost-of-living index update used in the most recent rebasing calculation and will apply any adjustments under (d)(7)(A). The resulting amount is the PDSDA for the payment division assigned to hospitals listed in (d)(8)(A) of this subsection.

(D) HHSC will assign a payment division designation to be used for a new hospital reimbursement rate. HHSC will calculate the rate as described in (d)(8)(B) and will apply any adjustments under (d)(7)(A), which will be the PDSDA for this designation.

(8) PDSDA calculation for specific types of hospitals.

(A) The following types of hospitals are assigned the universal mean plus the cost-of-living index update, as specified in subsection (d)(4) of this section, as their PDSDA:

(i) military hospitals;
(ii) out-of-state hospitals; and
(iii) newly enrolled hospitals.

(B) New Hospitals.

(i) For a new hospital, HHSC will locate the universal mean in an array of all hospitals' base year costs per claim from lowest to highest. HHSC will

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

(d) Payment Division Standard Dollar Amount (PDSDA) (continued)

then determine the group of claims located three percentile points above the universal mean. The new hospital is assigned the lowest dollar value claim within that percentile group, plus the cost-of-living index update calculated at the most recent rebasing, as its PDSDA.

(ii) This rate is effective for five years or until HHSC recalculates PDSDAs, whichever is earlier. After five years from the date HHSC applied the rate determined under (i), HHSC will assign the hospital the PDSDA described in (d)(6)(A) if HHSC has not recalculated PDSDAs.

(iii) A replacement facility constructed for a hospital that is currently enrolled as a Medicaid provider is reimbursed using either the PDSDA or final SDA of the existing provider or the PDSDA for new hospitals, whichever is greater.

(9) Merged hospitals.

(A) Notice. When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to HHSC's provider enrollment section, including documents verifying the merger status with Medicare. HHSC will assign to the merged entity a PDSDA, including adjustments, determined using a methodology described in (d)(9)(B) for all hospitals involved in the merger.

(B) Determining a merged entity's PDSDA or final SDA. HHSC will use the following process to determine a merged entity's PDSDA or final SDA:

(i) When HHSC recognizes a merged entity, after HHSC has completed a rebasing for each of the merging hospitals that had been a participating provider, and which none of the merging hospitals were a replacement facility receiving the new-hospital rate as referenced in (d)(8)(B)(iii), HHSC will determine the merged entity's PDSDA as follows:

(I) HHSC will calculate a new HSDA for the entity by combining the original base year cost per claim determined in (d)(3)(A) from the rebasing period for all hospitals involved in the merger;

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

(d) Payment Division Standard Dollar Amount (PDSDA) (continued)

(II) Using the resulting HSDA, HHSC will assign the merged entity to a payment division as described in (d)(5). HHSC will reimburse the merged entity at the PDSDA corresponding to that payment division number within the PDI described in (d)(7);
(III) HHSC will apply the resulting PDSDA to the surviving and terminated entities' Texas Provider Identification numbers retroactive to the date on which Medicare recognized the merged participating provider; and
(IV) HHSC will notify the merged entity of the PDSDA and the effective and termination dates of the Texas Provider Identification numbers for the involved hospitals.

(ii) When HHSC recognizes a merged entity involving at least one hospital having a PDSDA that is not based on the average base year cost per claim for that hospital, HHSC will assign the merged entity's PDSDA using the methodology in (d)(9)(B)(iii). Hospitals in this category may include:

(I) New hospitals;
(II) Newly enrolled hospitals; and
(III) Hospitals assigned the new-hospital PDSDA based on construction of a replacement facility.

(iii) When HHSC recognizes a merged entity described in (d)(9)(B)(ii), HHSC will determine the merged entity's PDSDA as follows:

(I) For each merging hospital, multiply the hospital's pre-merger PDSDA by the hospital's total number of claims for the state fiscal year claims file preceding the Medicare effective date of the merger;
(II) Sum the results of (I) for all merging hospitals;
(III) Divide the result of (II) by the total number of claims for all merging hospitals;
(IV) HHSC will assign the hospital to the payment division within the PDI that corresponds to the result of the calculation in (III);
(V) HHSC will apply the resulting PDSDA to the surviving and terminated entities' Texas Provider Identification numbers retroactive to the date on which Medicare recognized the merged participating provider; and
(VI) HHSC will notify the merged entity of the PDSDA and the effective and termination dates of the Texas Provider Identification numbers for the involved hospitals.

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

(d) Payment Division Standard Dollar Amount (PDSDA) (continued)

(iv) When HHSC recognizes a merged entity involving at least one hospital having a final SDA as a result of adjustments made to the entity's PDSDA under (d)(12), HHSC will determine the merged entity's final SDA as follows:

(I) HHSC will multiply the PDSDA or final SDA of each merging hospital by the case mix from the most recent rebasing file for that hospital;
(II) HHSC will sum the results obtained in (I) for all merging hospitals;
(III) HHSC will sum the case mix from the most recent rebasing file for all merging hospitals;
(IV) HHSC will divide the result obtained in (II) by the result obtained in (III) to determine the final SDA for the merged entity; and
(V) HHSC will apply the resulting final SDA to the surviving and terminated entities' Texas Provider Identification numbers retroactive to the date on which Medicare recognized the merged participating provider.

(v) When HHSC recognizes a merged entity during a rebasing in which each of the merging hospitals had been a participating provider:

(I) HHSC will calculate a new HSDA by combining the amounts determined in (d)(3)(A) for all hospitals involved in the merger;
(II) Using the resulting HSDA, HHSC will assign a PDSDA or final SDA for the merged entity as described for all other hospitals in this subsection; and
(III) For any concurrent or retroactive reimbursements prior to the effective date of a rebasing, HHSC will assign the merged entity's PDSDA or final SDA determined using either the methodology described in (d)(9)(B)(i), (d)(9)(B)(iii) or (d)(9)(B)(iv).

(C) HHSC will not recalculate the PDSDA or final SDA of a hospital acquired in an acquisition or buyout unless the acquisition or buyout resulted in the purchased or acquired hospital becoming part of another Medicaid participating provider. HHSC will continue to reimburse the acquired hospital based on the PDSDA or final SDA applied before the acquisition or buyout.

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

(d) Payment Division Standard Dollar Amount (PDSDA) (continued)

(10) TEFRA Cost for Rebasing. HHSC applies the cost reimbursement principles described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), to calculate the TEFRA cost for rebasing as follows:

(A) HHSC applies an interim rate for rebasing derived from tentative or final cost reports covering the base year. The interim rates for rebasing are applied to claims in months within the base year that coincide with months within the hospital's cost reporting periods.

(i) For cost report periods ending before October 1, 2007, HHSC calculates the interim rate by dividing a hospital's reported costs for providing Medicaid fee-for-service inpatient services by its allowed charges for those services.

(ii) For cost report periods ending on or after October 1, 2007, HHSC calculates the interim rate by:

(I) combining the hospital's reported costs for providing Medicaid fee-for service and Primary Care Case Management (PCCM) inpatient services;

(II) combining the hospital's allowed charges for providing Medicaid fee-for-service and PCCM inpatient services; and

(III) dividing the amount determined in (I) by the amount determined in (II).

(B) The TEFRA cost for rebasing is calculated by multiplying the Medicaid allowed charges for each base year claim by the interim rate described in subparagraph (A) of this paragraph.

(C) HHSC uses the tentative or final cost report settlement that is complete and available on the date HHSC sends the initial PDSDA notification letter to the hospital. The results of a tentative or final cost report settlement completed after the date HHSC sends the initial PDSDA notification letter to the hospital are not considered for purposes of this subsection.

(D) If there is no tentative or final cost report settlement available that coincides with any month of the base year, the TEFRA cost for rebasing is calculated using the latest available cost report period preceding the base year.

(E) If there is no tentative or final cost report settlement available for a provider, the TEFRA cost for rebasing is not calculated for this provider. In this instance the provider will be assigned a PDSDA as described in (d)(8).

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

(d) Payment Division Standard Dollar Amount (PDSDA) (continued)

(11) Correction of payment division error and reprocessing of claims.

(A) HHSC will place a hospital in the correct payment division if HHSC determines that the hospital was incorrectly assigned to a payment division.

(B) HHSC will reprocess all claims adjudicated during that state fiscal year that were paid to the hospital using the incorrect PDSDA by applying the corrected PDSDA to the claims. No corrections are made for claims adjudicated in previous state fiscal years.

(12) Adjustment of PDSDAs.

(A) HHSC will adjust a hospital's PDSDA pro rata among hospitals to the available funds PDSDA of 62.32 percent of the full cost rebased PDSDA.

(B) Transition Period. For claims with dates of admission between November 1, 2010, and August 31, 2011, HHSC will first calculate a proportionate reduction to the PDSDAs of all hospitals in accordance with (d)(12)(A). HHSC will then calculate a final SDA for each hospital using the following methodology:

(i) Calculate an estimated total revenue earned by each hospital using base year claims, PDSDAs and DRG relative weights in effect in federal fiscal year 2008;
(ii) Calculate an estimated total revenue that would have been earned by each hospital using base year claims for federal fiscal year 2008, PDSDAs proportionately adjusted under (d)(12)(A), and DRG relative weights calculated under (e);
(iii) Calculate the difference between (d)(12)(B)(i) and (d)(12)(B)(ii) for each hospital;

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

(d) Payment Division Standard Dollar Amount (PDSDA) (continued)

(iv) For each hospital where the result in (d)(12)(B)(iii) is negative, calculate a final SDA that limits the difference to ten percent of the result in (d)(12)(B)(iii) subject to limitations in (d)(12)(A)(vi). The limitation to ten percent of the result in (d)(12)(B)(iii) is intended to approximate total revenue from the base year and does not entitle the hospital to additional reimbursement if actual revenue reduction during the transition period is greater than ten percent;

(v) For each hospital where the result in (d)(12)(B)(iii) is positive, calculate a final SDA that limits the difference to thirty eight percent of the result in (d)(12)(B)(iii) subject to limitations in subparagraph (C) of this paragraph.

(vi) Notwithstanding any other provision, HHSC will not assign to any hospital a final SDA that will reimburse the hospital more than its estimated cost of providing Medicaid services, using base year claims for federal fiscal year 2008.

(vii) The hospitals described in (d)(8) will be assigned a PDSDA that is adjusted as described in (d)(12)(A).

(viii) This transition period expires August 31, 2011. For claims with dates of admission on or after September 1, 2011, HHSC will implement the proportionate PDSDA that was calculated in accordance with (d)(12)(A).

(C) No adjustment to a hospital's PDSDA can result in a final SDA that is below the minimum PDSDA described in (d)(7)(B).

(e) Diagnosis Related Groups (DRG) Statistical Calculations. HHSC adopts the classification of diagnoses defined in the Medicare DRG prospective payment system unless a revision is required based on Texas claims data or other factors, as determined by HHSC. HHSC recalibrates the relative weights, mean length of stay, and day outlier threshold whenever the PDSDAs are recalculated.

(1) Recalibration of relative weights. HHSC calculates a relative weight for each DRG as follows:

(A) Base year claims are grouped by DRG; and

(B) For each DRG, HHSC:

(i) sums the base year costs per claim as determined in subsection (d)(3)(A);

(ii) divides the result in (i) by the number of claims in the DRG; and

(iii) divides the result in (ii) by the universal mean, resulting in the relative weight for the DRG.

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

(e) Diagnosis Related Groups (DRG) Statistical Calculations (continued)

(2) Recalibration of mean length of stay (MLOS). HHSC calculates an MLOS for each DRG as follows:

(A) Base year claims are grouped by DRG; and

(B) For each DRG, HHSC:

(i) sums the number of days billed for all base year claims; and
(ii) divides the result in (i) by the number of claims in the DRG, resulting in the MLOS for the DRG.

(3) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows:

(A) Calculates for all claims the standard deviations from the MLOS in (e)(2);

(B) Removes each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS;

(C) Sums the number of days billed by all hospitals for a DRG for the remaining claims in (B);

(D) Divides the result in (C) by the number of remaining claims in (B);

(E) Calculates one standard deviation for the result in (D); and

(F) Multiplies the result in (E) by two and adds that to the result in (D); resulting in the day outlier threshold for the DRG.

(4) If a DRG has fewer than ten base year claims, HHSC will assign the corresponding Medicare relative weight and Medicare mean length of stay and will calculate the day outlier threshold based on the Medicare mean length of stay and standard deviation.

(5) If one of the DRGs specific to an organ transplant has less than five base year claims, HHSC will assign the corresponding Medicare relative weight and Medicare MLOS and will calculate the day outlier threshold based on the Medicare MLOS and standard deviation. In addition, HHSC adds a relative weight to account for the cost of procuring the organ to the Medicare relative weight for the DRG. HHSC uses the

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

(e) Diagnosis Related Groups (DRG) Statistical Calculations (continued)

organ procurement costs published by the Acquisition of Organ Procurement Organization (AOPO). To calculate the relative weight for procurement, HHSC divides the average cost of organ procurement by the universal mean for all claims.

(f) Request for Review. A hospital can request a review of the PDSDA or the DRG statistical calculations.

(g) Reimbursements.

(1) Calculating the payment amount. HHSC reimburses a hospital a prospective payment for covered inpatient hospital services by multiplying the hospital's PDSDA, or final SDA if adjustments were made under (d)(12), by the relative weight for the DRG assigned to the adjudicated claim. The resulting amount is the payment amount to the hospital.

(2) The prospective payment as described in paragraph (1) is considered full payment for covered inpatient hospital services. The PDSDA or final SDA result in (d) includes but is not limited to the following:

(A) capital costs;

(B) cost of indirect medical education;

(C) cost of malpractice insurance; and

(D) return on equity.

(3) Day and cost outlier adjustments. HHSC pays a day outlier or a cost outlier for medically necessary inpatient services provided to clients under age 21 in all Medicaid participating hospitals that are reimbursed under the prospective payment system. If a patient age 20 is admitted to and remains in a hospital past his or her 21st birthday, inpatient days and hospital charges after the patient reaches age 21 are included in calculating the amount of any day outlier or cost outlier payment adjustment.

(A) Day outlier payment adjustment. HHSC calculates a day outlier payment adjustment for each claim as follows:

(i) determines whether the number of medically necessary days allowed for a claim exceeds:

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

(g) Reimbursements (continued)

(I) the MLOS by more than two days; and
(II) the DRG day outlier threshold as calculated in (e)(3);

(ii) if (i) is true, subtracts the DRG day outlier threshold from the number of medically necessary days allowed for the claim;
(iii) multiplies the DRG relative weight by the PDSDA or final SDA if adjustments were made under (d)(12);
(iv) divides the result in (iii) by the DRG MLOS described in (e)(2), to arrive at the DRG per diem amount;
(v) multiplies the number of days in (ii) by the result in (iv); and
(vi) multiplies the result in (v) by 70 percent.

(B) Cost outlier payment adjustment. HHSC makes a cost outlier payment adjustment for an extraordinarily high-cost claim as follows:

(i) to establish a cost outlier, the cost outlier threshold must be determined by first selecting the lesser of the universal mean of base year claims multiplied by 11.14 or the hospital's PDSDA or final SDA multiplied by 11.14;
(ii) the full DRG prospective payment amount is multiplied by 1.5;
(iii) the cost outlier threshold is the greater of (i) or (ii);
(iv) the cost outlier threshold is subtracted from the amount of reimbursement for the claim established under cost reimbursement principles described in TEFRA; and
(v) the result in (iv) is multiplied by 70 percent to determine the amount of the cost outlier payment.

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

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

(4) A hospital may submit a claim to HHSC before a patient is discharged, but only the first claim for that patient will be reimbursed the amount determined by the prospective payment described in subsection (g)(1). Subsequent claims for that stay are paid zero dollars. When the patient is discharged and the hospital submits a final claim to ensure accurate calculation for potential outlier payments for clients younger than 21 years of age, HHSC recoups the first prospective payment and issues a final payment in accordance with subsections (g)(1) and (g)(3).

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

(g) Reimbursements (continued)

(5) Patient transfers and split billing. If a patient is transferred, HHSC establishes payment amounts as specified in (g)(5)(A) – (D). HHSC manually reviews transfers for medical necessity and payment.

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

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

(i) multiplies the DRG relative weight by the PDSDA or final SDA;
(ii) divides the result in (i) by the DRG MLOS described in (e)(2), to arrive at the DRG per diem amount; and
(iii) to arrive at the transferring hospital's payment amount:

(I) multiplies the result in (ii) by the lesser of the DRG MLOS, the transferring hospital's number of medically necessary days allowed for the claim, or 30 days; or
(II) for a patient under age 21, multiplies the result in (ii) by the lesser of the DRG MLOS or the transferring hospital's number of medically necessary days allowed for the claim.

(C) HHSC makes payments to multiple hospitals transferring the same patient by applying the per diem formula in (g)(5)(B) to all the transferring hospitals and the total DRG payment amount to the discharging hospital.

(D) HHSC performs a post-payment review to determine if the hospital that provided the most significant amount of care received the total DRG payment. If the review reveals that the hospital that provided the most significant amount of care did not receive the total DRG payment, an adjustment is initiated to reverse the payment amounts. The transferring hospital is paid the total DRG payment amount and the discharging hospital is paid the DRG per diem.

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

(h) Cost reports. Each hospital must submit an initial cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by HHSC.

(1) Each hospital must send a copy of all cost reports audited and amended by a Medicare intermediary to HHSC.

(2) HHSC uses data from these reports in rebasing years, in making adjustments as described in (d), and in completing cost settlements for children's hospitals and state-owned teaching hospitals as outlined in (j) and (l).

(3) Except as otherwise specified in (i), there are no cost settlements for inpatient services under the prospective payment system in this section.

(4) For hospitals reimbursed under this section, the cost settlement process is not limited by the TEFRA target cap.

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

(i) Hospitals in counties with 50,000 or fewer persons and certain other hospitals.

(1) Hospitals are reimbursed under this subsection if, as of the most recent decentennial census, the hospital is:

(A) located in a county with 50,000 or fewer persons;

(B) a Medicare-designated Rural Referral Center (RRC) or Sole Community Hospital (SCH) not located in a metropolitan statistical area (MSA), as defined by the U.S. Office of Management and Budget; or

(C) a Medicare-designated Critical Access Hospital (CAH).

(2) A hospital that qualifies under (i) is reimbursed for a cost reporting period the greater of:

(A) All Medicaid payments based on the prospective payment system; or

(B) The cost-reimbursement methodology described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) without the imposition of the TEFRA target cap described in (h)(4).

(3) The amounts in this subsection are calculated using the most recent data for Medicaid fee-for-service (FFS) and Primary Care Case Management (PCCM) inpatient services.

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

(j) In-state children's hospitals.

(1) HHSC or its designee reimburses in-state children's hospitals under methods and procedures described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(2) Interim payments are determined by multiplying a hospital's charges allowed under Medicaid by the interim rate effective on the date of admission. The interim rate is derived from the hospital's most recent tentative or final Medicaid cost report settlement.

(3) Interim payments are subject to settlement at both tentative and final audit of a hospital's cost report.

(4) Cost Settlement.

(A) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)).

(B) Notwithstanding the process in (A), HHSC or its designee uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for a hospital.

(C) HHSC or its designee selects a new base year period for calculating the TEFRA target cap at least every three years.

(D) HHSC or its designee increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the target cap by the CMS prospective payment system hospital market basket index adjusted to the hospital's fiscal year.

(E) For a newly recognized children's hospital, the base year period for calculating the TEFRA target cap is the hospital's first full 12-month cost reporting period occurring after the effective date of recognition. For each cost reporting period after the hospital's base year period, an increase in the TEFRA target cap will be applied as described in subparagraph (D), until the TEFRA target cap is recalculated in subparagraph (C).

(F) HHSC will recognize a hospital as a children's hospital if it meets the criteria required for certification as a children's hospital for Medicare.

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

(k) Out-of-state children's hospitals. HHSC or its designee calculates the prospective payment rate for an out-of-state children's hospital as follows:

(1) HHSC determines the overall average cost per discharge for all in-state children's hospitals by:

(A) Summing the Medicaid allowed cost from tentative or final cost report settlements for the base year; and

(B) Dividing the result in (A) by the number of in-state children's hospitals' base year claims described in (c)(4).

(2) HHSC determines the average relative weight for all of in-state children's hospitals' base year claims described in (c)(4) by:

(A) Assigning a relative weight to each claim pursuant to (e)(1);

(B) Summing the relative weights for all claims; and

(C) Dividing by the number of claims.

(3) The result in (1) is divided by the result in (2) to arrive at the adjusted cost per discharge.

(4) The adjusted cost per discharge in (3) is the payment rate used for payment of claims.

(5) The payment rate is not adjusted for inflation.

(6) HHSC will not recompute the adjusted cost per discharge effective September 1, 2008 or thereafter.

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

(l) State-Owned Teaching Hospital Reimbursement Methodology.

(1) For cost reporting periods beginning on or after September 1, 2008, HHSC or its designee reimburses state-owned teaching hospitals under methods and procedures described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(2) For dates of admission on or after September 1, 2003, state-owned teaching hospitals with allowable direct graduate medical education (DGME) costs will receive a pro rata share of their annual DGME cost based on the availability of appropriated funds. DGME expenses are not considered costs associated with inpatient hospital services and are not settled to cost.

(3) Interim payments are determined by multiplying a hospital's charges allowed under Medicaid by the interim rate effective on the date of admission derived from the hospital's most recent Medicaid cost report settlement, whether tentative or final.

(4) Interim payments are subject to settlement at both tentative and final audit of a hospital's cost report.

(5) Cost Settlement.

(A) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)).

(B) Notwithstanding the process in (1), HHSC or its designee uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for each hospital.

(C) HHSC or its designee selects a new base year period for calculating the TEFRA target cap at least every three years.

(D) HHSC or its designee increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the target cap by the CMS Prospective Payment System Hospital Market Basket Index adjusted to the hospital's fiscal year.

(m) – (s) Intentionally left blank.

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(C) If a payment division has fewer than 20 total base year claims, HHSC considers that payment division to be invalid. Hospitals within that payment division are assigned a PDSDA equal to the mathematically closest valid PDSDA.

(D) Minimum PDSDA. The minimum PDSDA of $1,600.00 is applied to any hospital with an HSDA equal to or less than $1,600.00.

(2) Payment Division Index (PDI).

(A) After all hospitals have been assigned a payment division number, HHSC may adjust the standard dollar amount for that payment division. The resulting PDSDA is the reimbursement rate for all hospitals assigned that payment division number. The PDI is the list of all payment division numbers and the corresponding valid PDSDAs.

(B) If the resulting PDSDA is less than $1,600.00, the minimum PDSDA is applied.

(C) HHSC will assign a payment division designation to the universal mean (average base year cost per claim for all hospitals) plus the cost-of-living update used in the most recent rebasing calculation and will apply any adjustments under subparagraph (A) of this paragraph. The resulting amount is the PDSDA for the payment division assigned to hospitals listed in paragraph (3)(A) of this subsection.

(D) HHSC will assign a payment division designation to be used for a new hospital reimbursement rate. HHSC will calculate the rate as described in paragraph (3)(B) of this subsection and will apply any adjustments under subparagraph (A) of this paragraph, which will be the PDSDA for this designation.

(E) The reimbursement for services effective September 1, 2010, will be equal to the payment that would have been made August 31, 2010, less 1 percent.

(3) PDSDAs for specific types of hospitals:

(A) The following types of hospitals are assigned the PDSDA described in (2)(C):

(i) military hospitals;
(ii) out-of-state hospitals; and
(iii) newly enrolled hospitals.

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(B) New Hospitals.

(i) For a new hospital, HHSC will locate the universal mean in an array of all hospitals' base year costs per claim from lowest to highest. HHSC will then determine the group of claims located within three percentile points above the universal mean. The new hospital is assigned the lowest dollar value claim within that percentile group, plus the cost-of-living update calculated at the most recent rebasing as its PDSDA.

(ii) This rate is effective for five years from the date the rate became effective or until HHSC recalculates PDSDAs, whichever is earlier. After five years from the date HHSC applied the rate determined under clause (i) of this subparagraph, HHSC will assign the hospital the PDSDA described in subparagraph (A) of this paragraph if HHSC has not recalculated PDSDAs.

(iii) A replacement facility constructed for a hospital that is currently enrolled as a Medicaid provider is reimbursed using either the PDSDA of the existing provider or the PDSDA for new hospitals, whichever is greater.

(4) Merged hospitals.

(A) Notice. When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to HHSC's provider enrollment contact, including documents verifying the merger status with Medicare. HHSC will assign to the merged entity a PDSDA, including adjustments, determined using a methodology described in subparagraph (B) of this paragraph for all hospitals involved in the merger.

(B) Determining a merged entity's PDSDA. HHSC will use the following process to determine a merged entity's PDSDA:

(i) When HHSC recognizes a merged entity after HHSC has completed a rebasing in which each of the merging hospitals had been a participating provider and after which none of the merging hospitals were a replacement facility receiving the new-hospital rate as referenced in paragraph (c)(3)(B) of this subsection, HHSC will determine the merged entity's PDSDA as follows:

(I) HHSC will calculate a new HSDA for the entity by combining the original base year cost per claim determined in paragraph (c) of this subsection from the rebasing period for all hospitals involved in the merger;

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(II) Using the resulting HSDA, HHSC will assign the merged entity to a payment division as described in paragraph (2) of this subsection. HHSC will reimburse the merged entity at the PDSDA corresponding to that payment division number within the PDI described in paragraph (2) of this subsection.

(III) HHSC will apply the resulting PDSDA to the surviving and terminated entities' Texas provider numbers retroactive to the date on which Medicare recognized the merged participating provider; and

(IV) HHSC will notify the merged entity of the PDSDA and the effective and termination dates of the Texas provider numbers for the involved hospitals.

(ii) When HHSC recognizes a merged entity involving at least one hospital having a PDSDA that is not based on the average base year cost per claim for that hospital, HHSC will assign the merged entity's PDSDA using the methodology in clause (iii) of this subparagraph. Hospitals in this category may include:

(I) New hospitals;

(II) Newly enrolled hospitals;

(III) Hospitals assigned the new-hospital PDSDA based on construction of a replacement facility.

(iii) When HHSC recognizes a merged entity described in clause (ii), HHSC will determine the merged entity's PDSDA as follows:

(I) For each merging hospital, multiply the hospital's pre-merger PDSDA by the hospital's total number of claims from the claims file for the state fiscal year preceding the Medicare effective date of the merger;

(II) Sum the results of subclause (I) for all merging hospitals;

(III) Divide the result of subclause (II) by the total number of claims for all merging hospitals;

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(IV) HHSC will assign the hospital to the payment division within the PDI that corresponds to the result of the calculation in subclause (III);

(V) HHSC will apply the resulting PDSDA to the surviving and terminated entities' Texas provider numbers retroactive to the date on which Medicare recognized the merged participating provider; and

(VI) HHSC will notify the merged entity of the PDSDA and the effective and termination dates of the Texas provider numbers for the involved hospitals.

(iv) When HHSC recognizes a merged entity during a rebasing in which each of the merging hospitals had been a participating provider:

(I) HHSC will calculate a new HSDA by combining the amounts determined in paragraph (c) of this subsection for all hospitals involved in the merger;

(II) Using the resulting HSDA, HHSC will assign a PDSDA for the merged entity as described for all other hospitals in this subsection;

(III) For any concurrent or retroactive reimbursements prior to the effective date of a rebasing, HHSC will assign the merged entity's PDSDA determined using either the methodology described in clause (i) or (ii).

(C) HHSC will not recalculate the PDSDA of a hospital acquired in an acquisition or buyout unless the acquisition or buyout resulted in the purchased or acquired hospital becoming part of another Medicaid participating provider. HHSC will continue to reimburse the acquired hospital based on the PDSDA applied before the acquisition or buyout.

(5) When the state agency or its designee determines that the state agency or its designee has made an error that, if corrected, would result in the standard dollar amount of the provider for which the error was made changing to a new payment division, either higher or lower, the state agency or its designee moves the provider into the correct payment division, and the