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State/Territory Name: Texas

State Plan Amendment (SPA) #: 12-38 NIRT

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Superseding Page Listing
4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

DEC 1 9 2012

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

RE: TN 12-38

Dear Ms. Ghahremani:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-38. This amendment purposes to transition from the use of Medicare Severity Diagnosis Groups (MS-DRG) to the 3M All Patient Refined Diagnosis Related Groups (APR-DRG) for inpatient hospital reimbursement. Additionally, this amendment removes provisions related to mitigation of disproportionate losses up to September 1, 2012. The amendment also updates pages for consistency and renumbers lists.

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 the assurances provided, Medicaid State plan amendment 12-38 is approved effective September 1, 2012. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

Cindy Mann
Director
Center for Medicaid and CHIP Services

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: **12-038**

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, 2012**

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:
42 CFR §440.10

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
   a. **FFY 2012** **$(2,322,483)**
   b. **FFY 2013** **$(29,140,049)**
   c. **FFY 2014** **$(29,751,244)**

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 purpose of this State Plan Amendment is to transition from the use of Medicare Severity Diagnosis Groups (MSDRG) to the 3M All Patient Refined Diagnosis Related Groups (APR-DRG) for hospital inpatient reimbursement. The amendment also removes provisions related to mitigation of disproportionate losses up to September 1, 2012. The amendment also updates pages for consistency and renumbers lists.

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 28, 2012

16. RETURN TO:
Chris Traylor
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 28 September, 2012

18. DATE APPROVED: DEC 19 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 September, 2012

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 and 9 to CMS Form 179

Transmittal Number 12-038

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 11-040)
Page 2	Page 2 (TN 11-040)
Page 3	Page 3 (TN 11-040)
Page 4	Page 4 (TN 11-040)
Page 5	Page 5 (TN 11-040)
Page 6	Page 6 (TN 11-040)
Page 7	Page 7 (TN 11-040)
Page 8	Page 8 (TN 11-040)
Deleted	Page 8a (TN 11-040)
Page 8a	Page 8b (TN 11-040)
Page 8b	Page 8c (TN 11-040)
Page 8c	Page 8d (TN 11-040)
Page 8d	Page 8e (TN 11-040)
Page 8e	Page 8f (TN 11-040)
Page 8f	Page 8g (TN 11-040)
Page 8g	Page 8h (TN 11-040)
Page 8h	Page 8I (TN 11-040)

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 (b).

(2) The prospective payment system described in this section applies to inpatient hospital payments effective September 1, 2012.

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

(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 (k)-(l).

(2) State-owned teaching hospitals. A state-owned teaching hospital is reimbursed in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) principles using the methodology described in (m).

(3) Freestanding psychiatric hospitals. A freestanding psychiatric hospital is reimbursed under the methodology described in (y).

(4) Hospitals in counties with 50,000 or fewer persons and certain other hospitals. A hospital in a county with 50,000 or fewer persons based on the 2000 decennial census and certain other hospitals are reimbursed under the methodology described in (j).

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

(3) Base standard dollar amount (base SDA) – A standardized payment amount calculated by HHSC, as described in (d), for the costs incurred by prospectively-paid hospitals in Texas for furnishing covered inpatient hospital services.

(4) Base year – For the purpose of this section, the base year is a state fiscal year (September through August) to be determined by HHSC.

(5) Base year claims – All Medicaid traditional fee-for-service (FFS) and Primary Care Case Management (PCCM) inpatient hospital claims for reimbursement filed by a hospital that:
(A) Had a date of admission occurring within the base year;
(B) Were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such claims that had zero inpatient days;
(C) Were not claims for patients who are covered by Medicare;
(D) Were not Medicaid spend-down claims;
(E) Were not claims associated with military hospitals, out-of-state hospitals, and hospitals described in (b).

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

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

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

(c) Definitions (continued).

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

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

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

(11) Diagnosis-related group (DRG) – The classification of medical diagnoses as defined in the 3M™ All Patient Refined Diagnosis Related Group (APR-DRG) system or as otherwise specified by HHSC.

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

(13) Final standard dollar amount (final SDA) – The rate assigned to a hospital after HHSC applies the add-ons and other adjustments described in this section.

(14) Geographic wage add-on – An adjustment to a hospital's base SDA to reflect geographical differences in hospital wage levels. Hospital geographical areas correspond to the Core-Based Statistical Areas (CBSAs) established by the federal Office of Management and Budget in 2003.

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

(16) Impact file – The inpatient prospective payment system (IPPS) final rule impact file that contains data elements by provider used by the Centers for Medicare and Medicaid Services (CMS) in calculating the most recent Medicare rates and impacts. The impact file is publicly available on the CMS website.

(17) 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.

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

(c) Definitions (continued).

(18) 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).

(19) 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.

(20) 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.

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

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

(23) 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.

(24) Rebasing – Calculation of the base year cost per claim for each Medicaid inpatient hospital.

(25) 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.

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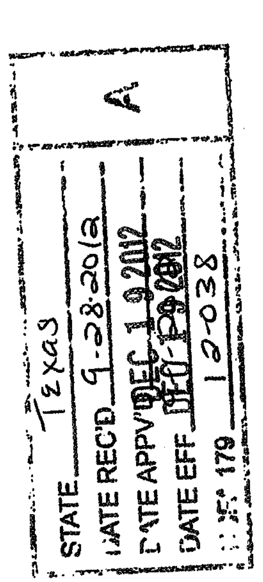
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (continued)

(c) Definitions (continued).

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

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



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

(29) 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.

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

(31) Trauma add-on – An adjustment to the base SDA for a trauma hospital to reflect the higher costs of obtaining and maintaining a trauma facility designation, as well as the direct costs of providing trauma services, relative to non-trauma hospitals or to hospitals with lower trauma facility designations.

(32) Trauma hospital – An inpatient hospital that meets the Texas Department of State Health Services criteria for a Level I, II, III, or IV trauma facility designation.

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

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

(1) HHSC calculates the universal mean as follows:

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

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

(d) Base standard dollar amount (SDA) calculations (continued).

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

(C) Divide the result in (d)(1)(B) by the total number of base year claims to derive the universal mean.

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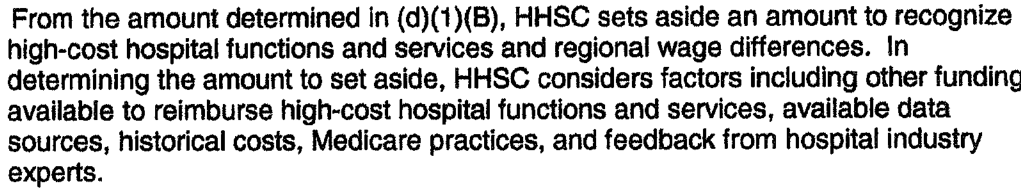

(2) From the amount determined in (d)(1)(B), HHSC sets aside an amount to recognize high-cost hospital functions and services and regional wage differences. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.

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

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

(3) HHSC divides the amount in (d)(2)(A) by the total number of base year claims to derive the base SDA.

(e) Add-ons.

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

(A) Geographic wage add-on, as described in (e)(3).
(B) Medical education add-on, as described in (e)(4).
(C) Trauma add-on, as described in (e)(5).

(2) If a hospital becomes eligible for the geographic wage add-on or the medical education add-on during the fiscal year, the hospital will not receive an increased final SDA. A hospital will become eligible for add-on adjustments for the geographic wage add-on and the medical education add-on upon next rebasing. If a hospital becomes eligible for the trauma add-on during the fiscal year, the hospital will receive an increased final SDA effective for claims that have a date of admission occurring on or after the first day of the next state fiscal year.

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

(e) Add-ons (continued).

(3) Geographic wage add-on.

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

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

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

(iii) HHSC divides the Medicare wage index factor for each CBSA by the lowest Medicare wage index factor identified in (e)(3)(A)(ii) and subtracts one from each resulting quotient to arrive at a percentage.

(iv) HHSC uses the result of the calculations in (e)(3)(A)(iii) to calculate each CBSA's add-on amount described in (e)(3)(C).

(B) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification.

(C) Add-on amount.

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

(ii) To determine the geographic wage add-on amount for each CBSA, HHSC multiplies the wage index factor determined in (e)(3)(A)(iv) for that CBSA by the percentage labor share of the base SDA calculated in (i).

(4) Medical education add-on.

(A) Eligibility. A teaching hospital is eligible for the medical education add-on. Each hospital is required to confirm that HHSC's determination of the hospital's eligibility and Medicare education adjustment factor for the add-on is correct.

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(e) Add-ons (continued).

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

(5) Trauma add-on.

(A) Eligibility.

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

(ii) HHSC initially uses the trauma level designation associated with the physical address of a hospital's Texas Provider Identifier (TPI). A hospital may request that HHSC use a higher trauma level designation associated with a physical address other than the hospital's TPI address.

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

(i) by 12.8 percent for hospitals with Level 1 trauma designation;
(ii) by 8.2 percent for hospitals with Level 2 trauma designation;
(iii) by 1.4 percent for hospitals with Level 3 trauma designation; or
(iv) by 0.9 percent for hospitals with Level 4 trauma designation.

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(f) Final SDA.

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

(A) Add all add-on amounts for which the hospital is eligible to the base SDA.
(B) Multiply the SDA determined in (f)(1)(A) by the hospital's total relative weight of base year claims.
(C) Sum the amount calculated in (f)(1)(B) for all hospitals.
(D) Divide the total funds appropriated for reimbursing inpatient hospital services under this section by the amount determined in (f)(1)(C).
(E) Multiply the SDA determined for each hospital in (f)(1)(A) by the percentage determined in (f)(1)(D).

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

(f) Final SDA (continued).

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

(3) For hospitals other than those identified in (f)(2) for which HHSC has no base year claim data, the final SDA is the base SDA plus any add-ons for which the hospital is eligible, multiplied by the percentage determined in (f)(1)(D).

(4) Merged hospitals.

(A) When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to verify the merger status with Medicare.

(B) HHSC will assign to the merged entity the final SDA assigned to the hospital associated with the surviving Texas Provider Identifier (TPI) and will reprocess all claims for the merged entity back to the date of the merger or the first day of the state fiscal year.

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

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

(g) Diagnosis-related groups (DRGs) statistical calculations. HHSC recalibrates the relative weights, mean length of stay (MLOS), and day outlier threshold whenever the base SDAs are recalculated.

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

(A) Base year claims are grouped by DRG.

(B) For each DRG, HHSC:

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

(ii) divides the result in (g)(1)(B)(i) by the number of claims in the DRG; and

(iii) divides the result in (g)(1)(B)(ii) by the universal mean, resulting in the relative weight for the DRG.

(2) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows:

(A) Base year claims are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the number of days billed for all base year claims; and

(ii) divides the result in (g)(2)(B)(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) Calculate for all claims the standard deviations from the MLOS in (g)(2);

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

(g) Diagnosis-related groups (DRGs) statistical calculations (continued).

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

(C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in (g)(3)(B);

(D) Divide the result in (g)(3)(C) by the number of remaining claims in (g)(3)(B);

(E) Calculate one standard deviation for the result in (g)(3)(D); and

(F) Multiply the result in (g)(3)(E) by two and add that to the result in (g)(3)(D); resulting in the day outlier threshold for the DRG.

(4) If a DRG has fewer than five base year claims, HHSC will use national claim statistics to assign:

(A) national relative weights recalibrated to relative weights calculated in (g)(1); and

(B) MLOS and day outlier as described in (g)(2) and (g)(3).

(h) Reimbursements.

(1) Calculating the payment amount. HHSC reimburses a hospital a prospective payment for covered inpatient hospital services by multiplying the hospital's final SDA as calculated in (f) by the relative weight for the DRG assigned to the adjudicated claim. The resulting amount is the payment amount to the hospital.

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

(h) Reimbursements (continued).

(2) The prospective payment as described in (h)(1) is considered full payment for covered inpatient hospital services. A hospital's request for payment in an amount higher than the prospective payment will be denied.

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

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

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

(I) the MLOS by more than two days; and

(II) the DRG day outlier threshold as calculated in (g)(3);

(ii) if (h)(3)(A)(i) is true, subtract the DRG day outlier threshold from the number of medically necessary days allowed for the claim;

(iii) multiply the DRG relative weight by the final SDA;

(iv) divide the result in (h)(3)(A)(iii) by the DRG MLOS described in (g)(2), to arrive at the DRG per diem amount;

(v) multiply the number of days in (h)(3)(A)(ii) by the result in (h)(3)(A)(iv); and

(vi) multiply the result in (h)(3)(A)(v) by 60 percent.

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

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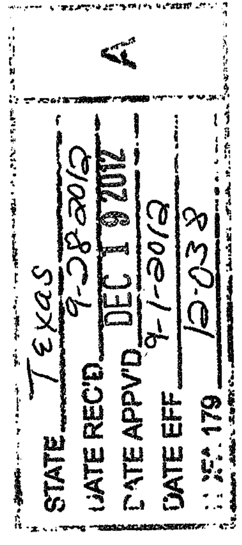
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (continued)

(h) Reimbursements (continued).



(i) to establish a cost outlier, the cost outlier threshold must be determined by first selecting the lesser of the universal mean of base year claims multiplied by 11.14 or the hospital's final SDA multiplied by 11.14;

(ii) the full DRG prospective payment amount is multiplied by 1.5;

(iii) the cost outlier threshold is the greater of (h)(3)(B)(i) or (h)(3)(B)(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) multiply the result in (h)(3)(B)(iv) by 60 percent to determine the amount of the cost outlier payment.

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

(D) If the hospital claim resulted in a downgrade of the DRG related to 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 prospective payment described in (h)(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 (h)(1) and (h)(3).

(5) Patient transfers and split billing. If a patient is transferred, HHSC establishes payment amounts as specified in (h)(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.

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

(h) Reimbursements (continued).

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

(i) multiply the DRG relative weight by the final SDA;
(ii) divide the result in (h)(5)(B)(i) by the DRG MLOS described in (g)(2), to arrive at the DRG per diem amount; and
(iii) to arrive at the transferring hospital's payment amount:

(I) for a patient age 21 or older, multiply the result in (h)(5)(B)(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, multiply the result in (h)(5)(B)(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 (h)(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.

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

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

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

(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, rural and certain other hospitals, and state-owned teaching hospitals as outlined in (j), (k) and (m).

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

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

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

(1) A hospital is reimbursed under this section if the hospital is:

(A) located in a county with 50,000 or fewer persons, based on the 2000 decennial census;

(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 is described in (j)(1) is reimbursed for inpatient services based on the cost-reimbursement methodology described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) without the imposition of the TEFRA target cap.

(3) Interim payments are determined by multiplying the hospital's charges that are allowed under Medicaid by the interim rate in effect on the patient's date of admission. The interim rate is 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.

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