

TITLE 1	ADMINISTRATION
PART 15	TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355	REIMBURSEMENT RATES
SUBCHAPTER J	PURCHASED HEALTH SERVICES
DIVISION 11	TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT
§355.8201	Waiver Payments to Hospitals for Uncompensated Care

#### PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes amendments to §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care, to revise the definition of a Rider 38 hospital.

#### BACKGROUND AND PURPOSE

The definition of a "Rider 38 hospital" in the current rule was adopted to conform to the definition of "rural hospital" contained in the General Appropriations Act for the 2014-15 biennium (S.B. 1, 83<sup>rd</sup> Leg., R.S., 2013, Article II, Health and Human Services Commission, Rider 38). The same definition was contained in the General Appropriations Act for the 2016-17 biennium (H.B. 1, 84<sup>th</sup> Leg., R.S., 2015, Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 58). The definition was changed during the recent legislative session, which is the reason HHSC proposes to amend the rule.

The General Appropriations Act for the 2018-19 biennium (S.B. 1, 85<sup>th</sup> Leg., R.S., 2017, Article II, Health and Human Services Commission, Rider 180) revises the definition of a rural hospital to be: (1) a hospital located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (2) a hospital designated by Medicare as a Critical Access Hospitals (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA); or (3) a hospital that (a) has 100 or fewer beds, (b) is designated by Medicare as a CAH, a SCH or a RRC, and (c) is located in an MSA.

Concurrently with this proposed rule amendment (elsewhere in this issue of the *Texas Register*), HHSC proposes amending §355.8052, Inpatient Hospital Reimbursement, to revise the definition of rural hospital consistent with Rider 180. For consistency in the use of terms in the administrative rules, HHSC proposes to revise §355.8201 to substitute the term "Rural hospital" for "Rider 38 hospital" throughout the rule and to define "Rural hospital" by reference to the definition in §355.8052.

## SECTION-BY-SECTION

Proposed amended §355.8201 changes "Rider 38 hospital" to "rural hospital" or "Rider 38" to "rural" throughout the rule. The proposed amendment also changes subsection (b) to define rural hospital by reference to §355.8052(b)(29) of this title (relating to Inpatient Hospital Reimbursement) instead of the current definition, stated above.

## FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years that the section will be in effect, there will be no effect on costs or revenues of state or local governments as a result of enforcing and administering the section as proposed.

## SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

Greta Rymal, Deputy Executive Commissioner for Financial Services, has also determined that there is no anticipated adverse economic impact on small businesses or micro-businesses required to comply with the section as proposed.

## ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated costs to persons who are required to comply with the section as proposed.

There is no anticipated negative impact on local employment.

## PUBLIC BENEFIT

Pam McDonald, Director of Rate Analysis, has determined that for each year of the first five years the section is in effect, the public will benefit from adoption of the section. The public benefit anticipated as a result of enforcing or administering the section will be consistency in the administrative rules in both the term used to refer to rural hospitals and in the definition of the term.

## TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of

government action and, therefore, does not constitute a taking under Government Code, §2007.043.

## PUBLIC HEARING

A public hearing to receive comments on the proposal will be scheduled after this rule is published in the *Texas Register* and will be held at HHSC, 4900 North Lamar Blvd., Austin, TX 78714-9030. The meeting date will be posted on the HHSC website (<https://hhs.texas.gov/about-hhs/communications-events/meetings-events>). Please contact Kevin Niemeyer, [kevin.niemeyer@hhsc.state.tx.us](mailto:kevin.niemeyer@hhsc.state.tx.us), if you have questions.

## PUBLIC COMMENT

Written comments on the proposal may be submitted to the HHSC Rate Analysis Department, 4900 North Lamar Blvd., Austin, TX 78714-9030 (Mail Code H-400); by fax to (512)-730-7475; or by e-mail to [RateAnalysisDept@hhsc.state.tx.us](mailto:RateAnalysisDept@hhsc.state.tx.us) within 30 days of publication of this proposal in the *Texas Register*.

To be considered, comments must be submitted no later than 30 days after the date of this issue of the *Texas Register*. The last day to submit comments falls on a Sunday; therefore, comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 1R039" in the subject line.

## STATUTORY AUTHORITY

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

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

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

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§355.8201. Waiver Payments to Hospitals for Uncompensated Care.

(a) Introduction. Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver payments are available under this section for eligible hospitals described in subsection (c) of this section. Waiver payments to hospitals must be in compliance with the Centers for Medicare & Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions and this section.

(b) Definitions.

(1) Affiliation agreement--An agreement, entered into between one or more privately-operated hospitals and a governmental entity that does not conflict with federal or state law. HHSC does not prescribe the form of the agreement.

(2) Aggregate limit--The amount of funds approved by the Centers for Medicare & Medicaid Services for uncompensated-care payments for the demonstration year that is allocated to each uncompensated-care provider pool, as described in subsection (f)(2) of this section.

(3) Anchor--The governmental entity identified by HHSC as having primary administrative responsibilities on behalf of a Regional Healthcare Partnership (RHP).

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

(5) Clinic--An outpatient health care facility, other than an Ambulatory Surgical Center or Hospital Ambulatory Surgical Center, that is owned and operated by a hospital but has a nine-digit Texas Provider Identifier (TPI) that is different from the hospital's nine-digit TPI.

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

(7) Delivery System Reform Incentive Payments (DSRIP)--Payments related to the development or implementation of a program of activity that supports a hospital's efforts to enhance access to health care, the quality of care, and the health of patients and families it serves. These payments are not considered patient-care revenue and are not offset against the hospital's costs when calculating the hospital-specific limit as described in §355.8066 of this title.

(8) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. This period corresponds to the Disproportionate Share Hospital program year.

(9) Disproportionate Share Hospital (DSH)--A hospital participating in the Texas Medicaid program that serves a disproportionate share of low-income patients and is eligible for additional reimbursement from the DSH fund.

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

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

(12) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.

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

(14) Large public hospital--An urban public hospital - Class one as defined in §355.8065 of this title (relating to Disproportionate Share Hospital Reimbursement Methodology).

(15) Mid-Level Professional--Medical practitioners which include only these professions: Certified Registered Nurse Anesthetists, Nurse Practitioners, Physician Assistants, Dentists, Certified Nurse Midwives, Clinical Social Workers, Clinical Psychologists, and Optometrists.

(16) Private hospital--A hospital that is not a large public hospital as defined in paragraph (14) of this subsection, a small public hospital as defined in paragraph (21) of this subsection or a state-owned hospital.

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

(18) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform. Regional Healthcare Partnerships will support coordinated, efficient delivery of quality care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations.

(19) RHP plan--A multi-year plan within which participants propose their portion of waiver funding and DSRIP projects.

(20) ~~Rural [Rider 38]~~ hospital--A hospital that is described in §355.8052(b)(29) of this title (relating to Inpatient Hospital Reimbursement) [located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated Rural Referral Center, a Sole Community Hospital, or a Critical Access Hospital].

(21) Small public hospital--An urban public hospital - Class two or a non-urban public hospital as defined in §355.8065 of this title.

(22) Transition payment--Payments available only during the first demonstration year to hospitals that previously participated in a supplemental payment program under the Texas Medicaid State Plan. For a hospital participating in the 2012 DSH program, the maximum amount a hospital may receive in transition payments is the lesser of:

(A) the hospital's 2012 DSH room; or

(B) the amount the hospital received in supplemental payments for claims adjudicated between October 1, 2010, and September 30, 2011.

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

(24) Uncompensated-care payments--Payments intended to defray the uncompensated costs of services that meet the definition of "medical assistance" contained in §1905(a) of the

Social Security Act that are provided by the hospital to Medicaid eligible or uninsured individuals.

(25) Uninsured patient--An individual who has no health insurance or other source of third-party coverage for services, as defined by CMS.

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

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

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

(A) a hospital must have a source of public funding for the non-federal share of waiver payments; and

(B) if it is a hospital not operated by a governmental entity, it must have filed with HHSC an affiliation agreement and the documents described in clauses (i) and (ii) of this subparagraph.

(i) The hospital must certify on a form prescribed by HHSC:

(I) that it is a privately-operated hospital;

(II) that no part of any payment to the hospital under this section will be returned or reimbursed to a governmental entity with which the hospital affiliates; and

(III) that no part of any payment under this section will be used to pay a contingent fee, consulting fee, or legal fee associated with the hospital's receipt of the supplemental funds.

(ii) The governmental entity that is party to the affiliation agreement must certify on a form prescribed by HHSC:

(I) that the governmental entity has not received and has no agreement to receive any portion of the payments made to any hospital that is party to the agreement;

(II) that the governmental entity has not entered into a contingent fee arrangement related to the governmental entity's participation in the waiver program;

(III) that the governmental entity adopted the conditions described in the certification form prescribed by or otherwise approved by HHSC pursuant to a vote of the governmental entity's governing body in a public meeting preceded by public notice published in accordance with the governmental entity's usual and customary practices or the Texas Open Meetings Act, as applicable; and

(IV) that all affiliation agreements, consulting agreements, or legal services agreements executed by the governmental entity related to its participation in this waiver payment program are available for public inspection upon request.

(iii) Submission requirements.

(I) Initial submissions. The parties must initially submit the affiliation agreements and certifications described in this subsection to the HHSC Rate Analysis Department on the earlier of the following occurrences after the documents are executed:

(-a-) The date the hospital submits the uncompensated-care application that is further described in paragraph (2) of this subsection; or

(-b-) Thirty days before the projected deadline for completing the IGT for the first payment under the affiliation agreement. The projected deadline for completing the IGT is posted on HHSC Rate Analysis' website for each payment under this section.

(II) Subsequent submissions. The parties must submit revised documentation as follows:

(-a-) When the nature of the affiliation changes or parties to the agreement are added or removed, the parties must submit the revised affiliation agreement and related hospital and governmental entity certifications.

(-b-) When there are changes in ownership, operation, or provider identifiers, the hospital must submit a revised hospital certification.

(-c-) The parties must submit the revised documentation thirty days before the projected deadline for completing the IGT for the first payment under the revised affiliation agreement. The projected deadline for completing the IGT is posted on HHSC Rate Analysis' website for each payment under this section.

(III) A hospital that submits new or revised documentation under subclause (I) or (II) of this clause must notify the Anchor of the RHP in which the hospital participates.

(IV) The certification forms must not be modified except for those changes approved by HHSC prior to submission.

(-a-) Within 10 business days of HHSC Rate Analysis receiving a request for approval of proposed modifications, HHSC will approve, reject, or suggest changes to the proposed certification forms.

(-b-) A request for HHSC approval of proposed modifications to the certification forms will not delay the submission deadlines established in this clause.

(V) A hospital that fails to submit the required documentation in compliance with this subparagraph will not receive a payment under this section.

(2) Uncompensated-care payments. For a hospital to be eligible to receive uncompensated-care payments, in addition to the requirements in paragraph (1) of this subsection, the hospital must:

(A) submit to HHSC an uncompensated-care application for the demonstration year, as is more fully described in subsection (g)(1) of this section, by the deadline specified by HHSC;

(B) submit to HHSC documentation of:

(i) its participation in an RHP; or

(ii) approval from CMS of its eligibility for uncompensated-care payments without participation in an RHP;

(C) be actively enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year; and

(D) have submitted, and be eligible to receive payment for, a Medicaid fee-for-service or managed-care inpatient or outpatient claim for payment during the demonstration year.

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

(A) If a hospital closes, loses its license, loses its Medicare or Medicaid eligibility, or files bankruptcy before receiving all or a portion of the uncompensated-care payments for a demonstration year, HHSC will determine the hospital's eligibility to receive payments going forward on a case-by-case basis. In making the determination, HHSC will consider multiple factors including whether the hospital was in compliance with all requirements during the demonstration year and whether it can satisfy the requirement to submit an uncompensated-care application for the demonstration year as described in subsection (g)(1)(C) of this section.

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

(d) Source of funding. The non-federal share of funding for payments under this section is limited to timely receipt by HHSC of public funds from a governmental entity.

(e) Payment frequency. HHSC will distribute waiver payments as follows and on a schedule to be determined by HHSC:

(1) Uncompensated-care payments will be distributed at least quarterly after the uncompensated-care application is processed.

(2) The payment schedule or frequency may be modified as specified by CMS or HHSC.

(f) Funding limitations.

(1) Payments made under this section are limited by the maximum aggregate amount of funds allocated to the provider's uncompensated-care pool for the demonstration year. If payments for uncompensated care for an uncompensated-care pool attributable to a demonstration year are expected to exceed the aggregate amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(5) of this section.

(2) HHSC will establish the following seven uncompensated-care pools: a state-owned hospital pool; a large public hospital pool; a small public hospital pool; a private hospital pool; a physician group practice pool; a governmental ambulance provider pool; and a publicly owned dental provider pool as follows:

(A) The state-owned hospital pool.

(i) The state-owned hospital pool funds uncompensated-care payments to state-owned teaching hospitals, state-owned IMDs and state chest hospitals.

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

(B) Rural hospital [~~Rider 38~~] set-aside amounts. HHSC will determine rural hospital [~~Rider 38~~] set-aside amounts as follows:

(i) Divide the amount of funds approved by CMS for uncompensated-care payments for the demonstration year by the amount of funds approved by CMS for uncompensated-care payments for the 2013 demonstration year and round the result to four decimal places.

(ii) Determine the small rural public hospital [~~Rider 38~~] set-aside amount by multiplying the value from clause (i) of this subparagraph by the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all rural [~~Rider 38~~] hospitals that are eligible to receive uncompensated-care payments under this section and that meet the definition of a small public hospital from subsection (b)(21) of this section. Truncate the resulting value to zero decimal places.

(iii) Determine the private rural hospital [~~Rider 38~~] set-aside amount by multiplying the value from clause (i) of this subparagraph by the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all rural [~~Rider 38~~] hospitals that are eligible to receive uncompensated-care payments under this section and that meet the definition of a private hospital from subsection (b)(16) of this section. Truncate the resulting value to zero decimal places.

(iv) Determine the total rural hospital [~~Rider 38~~] set-aside amount by summing the results of clauses (ii) and (iii) of this subparagraph.

(C) Non-state-owned provider pools. HHSC will allocate the remaining available uncompensated-care funds, if any, and the rural hospital [~~Rider 38~~] set-aside amount among the non-state-owned provider pools as described in this subparagraph. The remaining available



uncompensated-care funds equal the amount of funds approved by CMS for uncompensated-care payments for the demonstration year less the sum of funds allocated to the state-owned hospital pool under subparagraph (A) of this paragraph and the rural hospital [~~Rider 38~~] set-aside amount from subparagraph (B) of this paragraph.

(i) HHSC will allocate the funds among non-state-owned provider pools based on the following amounts:

(I) Large public hospitals:

(-a-) The sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all large public hospitals, as defined in subsection (b)(14) of this section, eligible to receive uncompensated-care payments under this section; plus

(-b-) An amount equal to the IGTs transferred to HHSC by large public hospitals to support DSH payments to themselves and private hospitals for the same demonstration year.

(II) Small public hospitals:

(-a-) The sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all non-rural [~~non-Rider 38~~] small public hospitals, as defined in subsection (b)(21) of this section, eligible to receive uncompensated-care payments under this section; plus

(-b-) An amount equal to the IGTs transferred to HHSC by small public hospitals to support DSH payments to themselves for Pass One and Pass Two payments for the same demonstration year.

(III) Private hospitals: The sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all non-rural [~~non-Rider 38~~] private hospitals, as defined in subsection (b)(16) of this section, eligible to receive uncompensated-care payments under this section.

(IV) Physician group practices: The sum of the unreimbursed uninsured costs and Medicaid shortfall for physician group practices, as described in §355.8202(g)(2)(A) of this title (relating to Waiver Payments to Physician Group Practices for Uncompensated Care).

(V) Governmental ambulance providers: The sum of the uncompensated care costs multiplied by the federal medical assistance percentage (FMAP) in effect during the cost reporting period for governmental ambulance providers, as described in §355.8600 of this title (relating to Reimbursement Methodology for Ambulance Services). Estimated amounts may be used if actual data is not available at the time calculations are performed.

(VI) Publicly-owned dental providers: The sum of the total allowable cost minus any payments for publicly owned dental providers, as described in §355.8441 of this title (relating to Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services). Estimated amounts may be used if actual data is not available at the time calculations are performed.

(ii) HHSC will sum the amounts calculated in clause (i) of this subparagraph.

(iii) HHSC will calculate the aggregate limit for each non-state-owned provider pool as follows:

(I) To determine the large public hospital pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds, from this subparagraph, by the amount calculated in clause (i)(I) of this subparagraph;

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places; and

(-c-) for the third demonstration year only, add \$136,309,422.

(II) To determine the small public hospital pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(II) of this subparagraph;

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places; and

(-c-) add the result from item (-b-) of this subclause to the amount calculated in subparagraph (B)(ii) of this paragraph.

(III) To determine the private hospital pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(III) of this subparagraph;

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places;

(-c-) add the result from item (-b-) of this subclause to the amount calculated in subparagraph (B)(iii) of this paragraph; and

(-d-) for the third demonstration year only, reduce the amount calculated in item (-c-) of this subclause by \$136,309,422.

(IV) To determine the physician group practice pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(IV) of this subparagraph; and

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places.

(V) To determine the maximum aggregate amount of the estimated uncompensated care costs for all governmental ambulance providers:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(V) of this subparagraph; and

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places.

(VI) To determine the publicly owned dental providers pool aggregate limit:

(-a-) multiply the remaining available uncompensated-care funds from this subparagraph by the amount calculated in clause (i)(VI) of this subparagraph; and

(-b-) divide the result from item (-a-) of this subclause by the amount calculated in clause (ii) of this subparagraph and truncate to zero decimal places.

(3) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section. If sufficient funds are not available for all payments for which a hospital is eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Application.

(A) Cost and payment data reported by the hospital in the uncompensated-care application is used to:

(i) calculate the annual maximum uncompensated-care payment amount for the applicable demonstration year, as described in paragraph (2) of this subsection; and

(ii) reconcile the actual uncompensated-care costs reported by the hospital for the data year with uncompensated-care waiver payments, if any, made to the hospital for the same period. The reconciliation process is more fully described in subsection (i) of this section.

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

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

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

(C) If a hospital withdraws from participation in an RHP, the hospital must submit an uncompensated-care application reporting its actual costs and payments for any period during which the hospital received uncompensated-care payments. The application will be used for the purpose described in paragraph (1)(A)(ii) of this subsection. If a hospital fails to submit the application reporting its actual costs, HHSC will recoup the full amount of uncompensated-care payments to the hospital for the period at issue.

(2) Calculation. A hospital's annual maximum uncompensated-care payment amount is the sum of the components below. In no case can the sum of payments made to a hospital for a demonstration year for DSH and uncompensated-care payments, less the payments described in paragraph (3) of this subsection, exceed a hospital's specific limit as determined in §355.8066 of this title after modifications to reflect the adjustments described in paragraph (4) of this subsection.

(A) The interim hospital specific limit, calculated as described in §355.8066 of this title, except that an IMD may not report cost and payment data in the uncompensated-care application for services provided during the data year to Medicaid-eligible and uninsured patients ages 21 through 64, less any payments to be made under the DSH program for the same demonstration year, calculated as described in §355.8065 of this title;

(B) Other eligible costs for the data year, as described in paragraph (3) of this subsection;

(C) Cost and payment adjustments, if any, as described in paragraph (4) of this subsection; and

(D) For each hospital eligible for payments under subsection (f)(2)(C)(i)(I) of this section, the amount transferred to HHSC by that hospital's affiliated governmental entity to support DSH payments for the same demonstration year.

(3) Other eligible costs.

(A) In addition to cost and payment data that is used to calculate the hospital-specific limit, as described in §355.8066 of this title, a hospital may also claim reimbursement under this section for uncompensated care, as specified in the uncompensated-care application, that is related to the following services provided to Medicaid-eligible and uninsured patients:

- (i) direct patient-care services of physicians and mid-level professionals;
- (ii) pharmacy services; and
- (iii) clinics.

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

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

(A) A hospital:

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

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

(B) Documentation supporting the request must accompany the application.

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

(C) In addition to being subject to the reconciliation described in subsection (i)(1) of this section which applies to all uncompensated-care payments for all hospitals, uncompensated-care payments for hospitals that submitted a request as described in subparagraph (A)(i) of this paragraph that impacted the interim hospital-specific limit described in paragraph (2)(A) of this subsection will be subject to the reconciliation described in subsection (i)(2) of this section.

(D) Notwithstanding the availability of adjustments impacting the interim hospital-specific limit described in this paragraph, no adjustments to the interim hospital-specific limit will be considered for purposes of Medicaid DSH payment calculations described in §355.8065 of this title.

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

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

(B) HHSC will calculate the following data points:

(i) For each provider, prior period payments to equal prior period uncompensated-care payments for the demonstration year.

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

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

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

(iii) The cumulative maximum payment amount to equal the sum of prior period payments from clause (i) of this subparagraph and the maximum uncompensated-care

payment for the payment period from clause (ii) of this subparagraph for all members of the pool combined.

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

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

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

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

(i) HHSC will calculate a capped payment amount equal to the product of the provider's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the pool-wide ratio calculated in subparagraph (B)(v) of this paragraph.

(ii) If the payment period is not the final payment period for the demonstration year, the revised maximum uncompensated-care payment for the payment period equals the lesser of:

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

(II) the difference between the capped payment amount from clause (i) of this subparagraph and the prior period payments from subparagraph (B)(i) of this paragraph.

(iii) If the payment period is the final payment period for the demonstration year:

(I) HHSC will calculate an IGT-supported maximum uncompensated-care payment for the payment period equal to the amount of the maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph that is supported by an IGT commitment.

(-a-) For hospitals and physician group practices, HHSC will obtain from each RHP anchor a current breakdown of IGT commitments from all governmental entities, including governmental entities outside of the RHP, that will be providing IGTs for uncompensated-care payments for each hospital and physician group practice within the RHP that is eligible for such payments for the payment period.

(-b-) Ambulance and dental providers will be assumed to have commitments for 100 percent of the non-federal share of their payments. The non-federal share for ambulance providers is provided through certified public expenditures (CPEs); for ambulance providers, references to IGTs in this subsection should be read as references to CPEs.

(II) HHSC will calculate an IGT-supported maximum uncompensated-care payment for the demonstration year to equal the IGT-supported maximum

uncompensated-care payment for the payment period from subclause (I) of this clause plus the provider's prior period payments from subparagraph (B)(i) of this paragraph.

(III) For providers with an IGT-supported maximum uncompensated-care payment amount for the demonstration year from subclause (II) of this clause that is less than or equal to their capped payment amount from clause (i) of this subparagraph, the provider's revised maximum uncompensated-care payment for the payment period equals the IGT-supported maximum uncompensated-care payment amount for the payment period from subclause (I) of this clause. For these providers, the difference between their capped payment amount from clause (i) of this subparagraph and their IGT-supported maximum uncompensated-care payment amount for the demonstration year from subclause (II) of this clause is their unfunded cap room.

(IV) HHSC will sum all unfunded cap room from subclause (III) of this clause to determine the total unfunded cap room for the pool.

(V) For providers with an IGT-supported maximum uncompensated-care payment amount for the demonstration year from subclause (II) of this clause that is greater than their capped payment amount from clause (i) of this subparagraph, the provider's revised maximum uncompensated-care payment amount for the payment period is calculated as follows:

(-a-) For each provider, HHSC will calculate an overage amount to equal the difference between the IGT-supported maximum uncompensated-care payment amount for the demonstration year from subclause (II) of this clause and their capped payment amount for the demonstration year from clause (i) of this subparagraph. Unfunded cap room from subclause (IV) of this clause will be distributed to these providers based on each provider's overage as a percentage of the pool-wide overage.

(-b-) For each provider, the provider's revised maximum uncompensated-care payment amount for the payment period is equal to the sum of its capped payment amount from clause (i) of this subparagraph and its portion of its pool's unfunded cap room from item (-a-) of this subclause less its prior period payments from subparagraph (B)(i) of this paragraph.

(E) Once reductions to ensure that uncompensated-care expenditures do not exceed the aggregate limit for the demonstration year for the pool are calculated, HHSC will not re-calculate the resulting payments for any provider for the demonstration year, including if the IGT commitments upon which the reduction calculations were based are different than actual IGT amounts.

(F) Notwithstanding the calculations described in subparagraphs (A) - (E) of this paragraph, if the payment period is the final payment period for the demonstration year, to the extent the payment is supported by IGT, each rural [~~Rider 38~~] hospital is guaranteed a payment at least equal to its interim hospital specific limit from paragraph (2)(A) of this subsection multiplied by the value from subsection (f)(2)(B)(i) of this section for the demonstration year less any prior period payments. If this guarantee will cause payments for a pool to exceed the aggregate pool limit, the reduction required to stay within the pool limit will be distributed proportionally across all non-rural [~~non-Rider 38~~] providers in the pool based on each provider's resulting payment from subparagraphs (A) - (E) of this paragraph as compared to the payments to all non-rural [~~non-Rider 38~~] hospitals in the pool resulting from subparagraphs (A) - (E) of this paragraph.

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

(7) Advance payments.

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

(B) The amount of the advance payments will be a percentage, to be determined by HHSC, of the annual maximum uncompensated-care payment amount calculated by HHSC for the preceding demonstration year.

(C) Advance payments are considered to be prior period payments as described in paragraph (5)(B)(i) of this subsection.

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

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

(h) Payment methodology.

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

(A) the payment amount for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

(B) the maximum IGT amount necessary for a hospital to receive the amount described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to a hospital will be determined based on the amount of funds transferred by the affiliated governmental entity or entities as follows:

(A) If the governmental entity transfers the maximum amount referenced in paragraph (1) of this subsection, the hospital will receive the full payment amount calculated for that payment period.

(B) If a governmental entity does not transfer the maximum amount referenced in paragraph (1) of this subsection, HHSC will determine the payment amount to each hospital owned by or affiliated with that governmental entity as follows:

(i) At the time the transfer is made, the governmental entity notifies HHSC, on a form prescribed by HHSC, of the share of the IGT to be allocated to each hospital owned by or affiliated with that entity and provides the non-federal share of uncompensated-care payments for each entity with which it affiliates in a separate IGT transaction; or

(ii) In the absence of the notification described in clause (i) of this subparagraph, each hospital owned by or affiliated with the governmental entity will receive a portion of its payment amount for that period, based on the hospital's percentage of the total payment amounts for all hospitals owned by or affiliated with that governmental entity.

(C) For a hospital that is affiliated with multiple governmental entities, in the event those governmental entities transfer more than the maximum IGT amount that can be provided for that hospital, HHSC will calculate the amount of IGT funds necessary to fund the hospital to its payment limit and refund the remaining amount to the governmental entities identified by HHSC.

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

(A) To the final payment up to the maximum amount;

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

(i) Reconciliation. Beginning in the third demonstration year, data on the uncompensated-care application will be used to reconcile actual costs incurred by the hospital for the data year with uncompensated-care payments, if any, made to the hospital for the same period:

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

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

(3) Transition payments are not subject to reconciliation under this subsection.

(4) If a hospital submitted a request as described in subsection (g)(4)(A)(i) of this section that impacted its interim hospital-specific limit, that hospital will be subject to an additional reconciliation as follows:

(A) HHSC will compare the hospital's adjusted interim hospital-specific limit from subsection (g)(4)(A)(i) of this section for the demonstration year to its final hospital-specific limit as described in §355.8066(c)(2) of this title for the demonstration year.

(B) If the final hospital-specific limit is less than the adjusted interim hospital-specific limit, HHSC will recalculate the hospital's uncompensated-care payment for the demonstration year substituting the final hospital-specific limit for the adjusted interim hospital-specific limit with no other changes to the data used in the original calculation of the hospital's uncompensated-care payment other than any necessary reductions to the original IGT amount and will recoup any payment received by the hospital that is greater than the recalculated uncompensated-care payment. Recouped funds may be redistributed to other hospitals that received payments less than their actual costs.

(j) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a hospital's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the hospital will be returned to the entity that owns or is affiliated with the hospital.

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



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

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

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

(k) Penalty for failure to complete Category 4 reporting requirements for Regional Healthcare Partnerships. Hospitals must comply with all Category 4 reporting requirements set out in Chapter 354 of this title, Subchapter D (relating to Texas Healthcare Transformation and Quality Improvement Program). If a hospital fails to complete required Category 4 reporting measures by the last quarter of a demonstration year:

(1) the hospital will forfeit its uncompensated-care payments for that quarter; or

(2) the hospital may request from HHSC a six-month extension from the end of the demonstration year to report any outstanding Category 4 measures.

(A) The fourth-quarter payment will be made upon completion of the outstanding required Category 4 measure reports within the six-month period.

(B) A hospital may receive only one six-month extension to complete required Category 4 reporting for each demonstration year.