TO: Health and Human Services Commission Executive Council

DATE: December 6, 2018

FROM: Charles Greenberg, Director of Hospital Finance and Waiver Programs

AGENDA ITEM: 3

SUBJECT: DY7 and DY8 Rural Uncompensated Care (UC)

BACKGROUND: ☒ Federal ☐ Legislative ☒ Other: Program Initiative

The Texas Health and Human Services Commission adopts an amendment to 1 TAC §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care.

The purpose of the amendment is to alter the final payment methodology for the Uncompensated Care (UC) program in demonstration years (DYs) 7 and 8. Since 2012, the Texas Health and Human Services Commission has operated the UC pool under the authority of a federally approved 1115 demonstration waiver. This pool of limited funds is a vital resource to hundreds of hospitals throughout Texas for provision of uncompensated care. Historically, HHSC provided preferential treatment to rural hospitals in the UC program. This preferential treatment comes in the form of a guarantee that a rural hospital will receive a UC payment equal to a particular amount of that hospital's eligible uncompensated costs.

The original intent behind this decision was to provide "a certain level of protection in UC in recognition of the financial vulnerability of [rural] hospitals and the critical role they play in preserving the rural safety net." (39 TexReg 4844, June 27, 2014). Since that time, a growing number of large urban hospitals obtained Medicare designations as Rural Referral Centers (RRCs). In addition, a federal court decision this year caused a statewide change in the way HHSC had to calculate eligible costs that are reimbursable through the UC program.

As a result of these unanticipated changes, HHSC is adopting two amendments to the UC payment methodology. First, HHSC is adopting to eliminate preferential treatment in UC for an RRC with more than 100 beds in a metropolitan statistical area beginning in DY 8. These hospitals are known as "urban RRCs."

Second, HHSC is adopting to limit the preferential treatment to urban RRCs in DY 7. HHSC recognizes that these hospitals qualified for preferential treatment for most of the demonstration year. However, the unanticipated effects of the aforementioned federal court decision in combination with the growth of urban RRCs receiving preferential treatment would result in an extremely inequitable shift from the majority of hospitals participating in the UC program to the very few urban RRCs. In fact, all 12 urban RRCs would receive 18.46 percent of the entire UC pool while only accounting for 7.04 percent of all eligible uncompensated costs throughout Texas.

As a result, HHSC allows urban RRCs to receive preferential treatment up to the level of eligible uncompensated costs, in the aggregate, that would have been calculated for those hospitals prior to the federal court decision. That results in urban RRCs receiving 54 percent of their eligible uncompensated costs. When evaluating an appropriate response to the unanticipated events, HHSC reviewed multiple options and received feedback from a large number of stakeholders. However, HHSC continued to receive feedback in the form of comments to this amendment.

ISSUES AND ALTERNATIVES:

HHSC previously proposed an amendment to 1 TAC §355.8201 on July 27, 2018 (43 TexReg 4911). HHSC withdrew the proposed amendment on September 10, 2018, but has included those changes in this rule amendment.

STAKEHOLDER INVOLVEMENT:

During the month of August 2018, HHSC engaged in a process to solicit feedback on potential options. Comments received from stakeholders were reviewed by HHSC staff and taken into consideration.

FISCAL IMPACT:

☒ Yes

	SFY 1	SFY 2	SFY 3	SFY 4	SFY 5
State	$1,054,155	$2,232,040	$0	$0	$0
Federal	$1,467,144	$2,944,305	$0	$0	$0
Total	$2,521,299	$5,176,345	$0	$0	$0

SERVICES IMPACT STATEMENT:

The rules will benefit HHSC's clients because for both DYs 7 and 8, certain local governmental entities will receive higher UC payments compared to the current rule.

RULE DEVELOPMENT SCHEDULE:

September 21, 2018	Publish proposed rules in *Texas Register*
November 8, 2018	Present to the Medical Care Advisory Committee
November 16, 2018	Publish adopted rules in *Texas Register*
November 26, 2018	Effective date
December 6, 2018	Present to HHSC Executive Council

ADOPTION PREAMBLE

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care. The amendment is adopted with changes to the proposed text as published in the September 21, 2018, issue of the *Texas Register* (43 TexReg 4063). The text of the rule will be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the amendment is to alter the final payment methodology for the Uncompensated Care (UC) program in demonstration years 7 and 8. Since 2012, HHSC has operated the UC pool under the authority of a federally approved 1115 demonstration waiver. This pool of limited funds is a vital resource for hundreds of Texas hospitals that provide uncompensated care.

Historically, HHSC provided preferential treatment to rural hospitals in the UC program by making a rural hospital's UC payment equal to a particular amount of that hospital's eligible uncompensated costs. The original intent behind this decision was to provide "a certain level of protection in UC in recognition of the financial vulnerability of [rural] hospitals and the critical role they play in preserving the rural safety net." (39 TexReg 4844, June 27, 2014). Since that time, a growing number of large urban hospitals obtained Medicare designations as Rural Referral Centers (RRCs). In addition, the recent federal court ruling in *Children's Hosp. Association of Texas v. Azar* ("CHAT ruling") caused a statewide change in the way HHSC must calculate eligible costs that are reimbursable through the UC program.

As a result of these unanticipated developments, HHSC is eliminating preferential treatment in UC for RRCs with more than 100 beds in a metropolitan statistical area (MSA) beginning in demonstration year 8. These hospitals are known as "urban RRCs." HHSC is also limiting the preferential treatment for urban RRCs in demonstration year 7. The unanticipated effects of the aforementioned CHAT ruling in combination with the growth of urban RRCs receiving preferential treatment would result in an extremely inequitable shift from the majority of hospitals participating in the UC program to the very few urban RRCs. In fact, the 12 urban RRCs would receive 18.46 percent of the entire UC pool while only accounting for 7.04 percent of all eligible uncompensated costs throughout Texas.

As a result, for demonstration year 7 only, HHSC is allowing urban RRCs to receive preferential treatment up to the level of eligible uncompensated costs, in the aggregate, that would have been calculated for those hospitals

prior to the CHAT ruling. This allows urban RRCs to receive 54 percent of their eligible uncompensated costs.

HHSC considered a variety of different options before proposing this amendment. HHSC met with and received feedback from a large number of stakeholders prior to publication of the proposal. After publication, HHSC evaluated feedback in the form of written comments and oral testimony received during a public hearing.

HHSC is making the following changes upon adoption:

First, HHSC is reformatting the definition of “Rural hospital.”

Second, HHSC is correcting and updating an internal reference in §355.8201(g)(4)(C) that was incorrect.

Third, HHSC is clarifying that the 100 beds referenced in the definitions refers to “licensed beds,” not “staffed beds.”

Fourth, HHSC is clarifying the date by which new affiliation agreements must be submitted.

COMMENTS

The 30-day comment period ended October 22, 2018.

During this period, HHSC received comments regarding the proposed amendments from a member of the Texas Legislature and 11 entities, including:

Baptist Hospitals of Southeast Texas
Catholic Health Initiatives St. Luke’s Health
Children’s Hospital Association of Texas
CHRISTUS Health
Community Health Systems
Parkland Health and Hospital System
Steward Health Care System
Teaching Hospitals of Texas
Tenet Healthcare Corporation
Texas Hospital Association
Universal Health Systems

A summary of comments relating to the rule and HHSC's responses follows.

Comments Related to Demonstration Year 7

Comment: Some commenters are opposed to the proposed change to the level of preferential treatment for urban RRCs in demonstration year 7. The commenters provided multiple reasons for opposing the proposed change. First, some commenters believe that the legislature intends for urban RRCs to be treated similarly to rural hospitals. Second, some commenters argue that the proposed change is inappropriate because they have set their budgets. Third, some commenters argue that the proposed change is a retroactive action by the state in violation of the Texas Constitution. Fourth, one commenter believes that adopting a change "so close to the end of a demonstration year" sets a dangerous precedent. Fifth, some hospitals argue that the proposed change exacerbates inequities and will result in some classes of hospital receiving reimbursement above allowable costs.

Response: HHSC understands that hospitals eligible to participate as urban RRCs would receive lower UC payments compared to rural hospitals. However, after extensive analysis and discussion, HHSC believes it is contrary to good public policy for urban RRCs to receive an unanticipated windfall at the expense of other Texas safety net hospitals.

Regarding legislative intent, the 85th Legislature included a definition of rural hospital in the General Appropriations Act that excludes large urban RRCs. The legislative intent of the 2017 act was that urban RRCs should not receive preferential treatment intended for rural hospitals. The decision was made to allow for a transition period described in this rule for large urban RRCs in UC. Contrary to the comment, there is nothing to indicate that the 84th or 85th Legislatures intended to benefit large urban RRCs as rural hospitals. The legislative intent of Rider 38 in the 2013 General Appropriations Act, where a description of preferential treatment for rural hospitals was first placed, was to preserve the safety net "regardless of where located." There were no large hospitals with a Rural Referral Center designation that were located in metropolitan statistical areas in 2013. HHSC does not believe the legislature could have intended to give preferential treatment to a category of hospital that did not, at the time, exist.

Regarding a facility having a set budget, HHSC appreciates the need for a facility to plan its financing. However, HHSC cannot take into account the varying budget cycles for every facility in the state when making policy decisions, as every facility has different budget years. HHSC strives to balance the good of the public at large and the needs of individual facilities when making policy decisions.

Regarding the claim that HHSC is taking a retroactive action in violation of the Texas Constitution, HHSC notes that the proposed amendment to alter the final payment methodology in demonstration year 7 is not a retroactive application of the law. The final payments for year 7 of the demonstration project have not been made yet, and payment recipients were notified by letter on August 9, 2018, that adjustments to the payment methodology for the final payment for year 7 were imminent. Under both the federal and state constitutions, a law cannot be deemed "retroactive" in violation of the constitution unless it can be shown that the application of the law would take away or impair a vested right acquired under existing law; an "expectancy" based upon anticipated continuance of present laws does not create a vested right for purposes of either the federal or state constitutions.

Regarding the claim that HHSC is creating dangerous precedent by making a change so close to the end of a demonstration year, HHSC respectfully disagrees. Again, HHSC strives to balance the good of the public at large and the needs of individual facilities when making policy decisions. HHSC believes that the shift of public funds between types of hospitals that would occur if no change is made sets a dangerous precedent itself, if not outright creates danger to the health care safety net. Regardless of the precedent, HHSC created a reasoned compromise that would allow for urban RRCs to receive the benefit they rationally would have expected at the beginning of demonstration year 7.

Regarding the claim that adopting this rule exacerbates inequalities and allows for some hospital classes to receive reimbursement above their uninsured and Medicaid allowable costs, HHSC respectfully disagrees. First, given that the UC program is capped, HHSC must rationally apportion a finite amount of funding among hundreds of hospitals. The change in payment methodology for demonstration year 7 actually decreases the inequalities between classes relative to the methodology that would exist without this change since the result is more in line with expectations at the beginning of the demonstration year. Additionally, whether or not a hospital is above its allowable costs depends on how one calculates those costs. Given the change in the calculation of the Hospital-Specific Limit (HSL) as a result of the CHAT ruling, HHSC does not believe any class is paid above its allowable costs.

No changes were made in response to this comment.

Comment: Several commenters are supportive of the proposed change to the level of preferential treatment for urban RRCs in demonstration year 7. However, while some commenters support the change outright, others are

willing to accept the proposed change only if it is necessary. Such commenters believe that the option HHSC proposed is the most appropriate compromise.

Response: HHSC appreciates the comment. The shift in funds to certain provider classes was unexpected and created inequalities among the classes. HHSC continues to believe that such a shift is inappropriate. As such, HHSC will adopt the compromise policy of allowing urban RRCs to receive preferential treatment in accord with what they would have expected at the beginning of the demonstration year. No changes were made in response to this comment.

Comment: While several commenters were supportive of a change to the demonstration year 7 payment methodology, some commenters requested that HHSC allow for the full preferential treatment that rural hospitals receive but based on the HSL in use prior to the CHAT ruling.

Response: HHSC appreciates the comment but cannot adopt the recommendation. The HSL calculation is used across multiple programs that, to a great extent, are linked together (i.e., UC, Disproportionate Share Hospital program, and the Uniform Hospital Rate Increase Program). Using a different HSL methodology in one program as opposed to others is difficult and could have unanticipated results. Using two different HSL methodologies in the same program would be arbitrary. Additionally, it would be administratively burdensome to complete multiple calculations of the HSL with varying methodologies depending on the program or type of facility. No changes were made in response to this comment.

Comments Relating to Demonstration Year 8

Comment: One commenter urged HHSC to maintain the Rider 38 preferential treatment for urban RRCs in the UC program for demonstration year 8.

Response: HHSC disagrees with the comment. The Texas Legislature did not intend to allow urban RRCs to receive preferential treatment in the UC program, and the change for demonstration year 8 will allow HHSC to treat urban RRCs just as they are in the context of Medicaid rates. Additionally, this further alleviates an unanticipated inequality among the hospital classes within the UC program. HHSC notes that urban RRCs still receive preferential treatment in demonstration year 7. No changes were made in response to this comment.

Comment: Some commenters urged HHSC to carry over the proposed change in methodology for demonstration year 7 to demonstration year 8.

Response: HHSC disagrees with the comment. The Texas Legislature did not intend to allow urban RRCs to receive preferential treatment in the UC program, and the change for demonstration year 8 will allow HHSC to treat urban RRCs just as they are in the context of Medicaid rates. Additionally, this further alleviates an unanticipated inequality among the hospital classes within the UC program. No changes were made in response to this comment.

Comment: Some commenters support the proposed elimination of preferential treatment for urban RRCs in the UC program for demonstration year 8.

Response: HHSC appreciates and agrees with the comment. No changes were made in response to this comment.

Comments Relating to the Appropriate Definition of “Rural Hospital”

Comment: One commenter claims that HHSC acted arbitrarily by excluding facilities in a county of more than 60,000 people from the definition of “rural hospital.” The commenter recommends that HHSC move the population cutoff to more than 280,000.

Response: HHSC disagrees with the commenter as the definition of “rural hospital” is not arbitrary. The proposed definition mirrors the prior definition of “Rider 38 hospital” in regards to the population cutoff of hospitals within a county of 60,000 or fewer people. This part of the definition existed since 2013. In addition, this definition is taken from the General Appropriations Act of the 85th Legislature, with the exception of Sole Community Hospitals. The Texas Legislature directed HHSC to give hospitals that meet this definition of “rural hospital” preferential treatment in the context of hospital rates. Streamlining the definition across all hospital payment programs, to the extent feasible, is rational as it allows like hospitals to be treated consistently in each payment program. No changes were made in response to this comment.

Comment: One commenter recommends that HHSC use other factors to determine if a facility is a “rural hospital.”

Response: HHSC disagrees with the comment. This definition is taken from the General Appropriations Act of the 85th Legislature, with the exception of Sole Community Hospitals. The Texas Legislature directed HHSC to give hospitals that meet this definition of “rural hospital” preferential treatment in

the context of hospital rates. Streamlining the definition across all hospital payment programs is rational as it allows like hospitals to be treated consistently in each payment program. No changes were made in response to this comment.

Comment: One commenter believes that a hospital's location within a MSA should not be the deciding factor for urban or rural status in demonstration year 8. Specifically, the commenter states that the MSA is not designed to determine an urban or rural classification nor is it designed to be used in program funding formulas. Instead, the commenter recommends that HHSC take additional factors into account when determining a rural hospital. The two specific factors recommended by the commenter are 1) whether a hospital serves remote and rural areas as demonstrated by a population density of less than 100 per square mile and 2) whether a hospital is located within 10 miles of the Mexico border and in a county with a population density less than 150 per square mile.

Response: HHSC disagrees with the comment. This definition is taken from the General Appropriations Act of the 85th Legislature, with the exception of Sole Community Hospitals. The Texas Legislature directed HHSC to give hospitals that meet this definition of "rural hospital" preferential treatment in the context of hospital rates. Streamlining the definition across all hospital payment programs is rational as it allows like hospitals to be treated consistently in each payment program. No changes were made in response to this comment.

Other Comments Received

Comment: One commenter requested that in counting the number of beds to determine rural hospital and urban RRC status, HHSC should utilize staffed beds as opposed to licensed beds.

Response: HHSC utilizes licensed beds across all of its payment programs when determining eligibility. Licensed beds are a standard metric that is not susceptible to large variation between, or within, a program year. Therefore, HHSC clarified the rule to reflect that the determination of rural hospitals and urban RRCs is based on licensed beds.

Comment: One commenter claims that HHSC violated the Texas Administrative Procedure Act. First, the commenter claims that HHSC violated Texas Government Code §2001.024(4) by failing to provide an analysis of the fiscal impact to the city of Beaumont and Jefferson County. Second, the commenter claims that HHSC violated Government Code §2001.024(5) by failing to provide an analysis of the economic costs to

persons and impact on local employment to the city of Beaumont and Jefferson County.

Response: HHSC assumes that the analyses to which the commenter refers are the Government Growth Impact Statement described by Government Code §2001.0221, the Local Employment Impact Statement described by Government Code §2001.022, and the requirement of Government Code §2001.024(a)(5) that the notice include information regarding the costs to persons required to comply with the rule. These statements must be included in the notice of a proposed rule or rule amendment per Government Code §§2001.024(a)(4), (a)(5), and (a)(6). The statements were included in the notice of the proposed rule amendment.

With regard to Government Code §2001.024(a)(4), HHSC believes that the commenter could be referring to the general requirement for fiscal notes described in that section or the Government Growth Impact Statement required by Government Code §2001.0221. The general requirement for fiscal notes was fulfilled, as nothing in Government Code §2001.024(a)(4) requires a state agency to calculate the fiscal effect of a change in policy to governmental entities solely because a private entity within those governmental jurisdictions may lose funds.

As to the Government Growth Impact Statement, HHSC restates from the preamble of the proposal that it has determined that during the first five years that the rule will be in effect:

(1) the proposed rule will not create or eliminate a government program;
(2) implementation of the proposed rule will not affect the number of employee positions;
(3) implementation of the proposed rule will not require an increase or decrease in future legislative appropriations;
(4) the proposed rule will not affect fees paid to the agency;
(5) the proposed rule will not create a new rule;
(6) the proposed rule will limit an existing rule;
(7) the proposed rule will not change the number of individuals subject to the rule; and
(8) the proposed rule will not affect the state's economy.

HHSC also notes that Government Code §2001.0221(c) expressly provides that failure to comply with the section does not impair the legal effect of a rule adopted under Chapter 2001.

With regard to the requirement of Government Code §2001.024(a)(5) that the analysis describe the economic costs to persons regulated by the rule, HHSC restates from the preamble of the proposal that HHSC has determined there are no anticipated economic costs to persons who are required to comply with the section as proposed.

With regard to the Local Employment Impact Statement required by Government Code §§2001.022 and 2001.024(a)(6), HHSC restates from the preamble of the proposal that there is a possibility of a negative impact on local employment in some communities and a positive impact in others. The change in reimbursement methodology for urban RRCs will impact distribution of UC funds to participating providers. Certain providers will receive greater reimbursement while urban RRCs will receive less than they would have under the previous rule. HHSC lacks sufficient data to both predict communities in which there may be an employment impact and to determine the potential impacts on local employment in those communities. HHSC also notes that Government Code §2001.022(c) provides that failure to comply with this section does not impair the legal effect of a rule adopted under Chapter 2001.

No changes were made in response to this comment.

Comment: One commenter claims that HHSC violated Government Code §2007.043 by failing to provide an assessment of the takings impact of the proposed changes.

Response: HHSC restates from the preamble of the proposal 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. A providing hospital's not yet calculated or received payment under the UC program is not "property" for purposes of the taking clauses of either the federal or state constitutions. Nor does an "expectancy" based upon anticipated continuance of present laws create a vested right for purposes of either the federal or state constitutions. No changes were made in response to this comment.

Comment: One commenter supports the use of the HSL methodology resulting from the disposition of the CHAT ruling described above.

Response: HHSC appreciates this comment and will continue to use a single HSL methodology for its payment programs. No changes were made in response to this comment.

Comment: One commenter requests that HHSC utilize the HSL methodology in operation prior to the CHAT ruling. The commenter claims that this method is more equitable for the hospitals that provide more uncompensated care than any other class.

Response: HHSC cannot utilize the HSL methodology in operation prior to the CHAT ruling. HHSC believes that given its current state plan, rules, and past practice, it would be inconsistent with court direction to use the prior HSL methodology. No changes were made in response to this comment.

Comment: Some commenters request that HHSC implement a different HSL calculation such that other insurance and Medicare payments are included up to the Medicaid allowable cost. Commenters point to Texas Human Resources Code §32.0284 as authority for HHSC to take such action. The commenter claims that this method is more equitable for the hospitals that provide more uncompensated care than any other class. Additionally, the commenter says that no state plan amendment would be necessary.

Response: HHSC appreciates the comment but declines to adopt it for demonstration year 7. HHSC is evaluating the proposal for demonstration year 8, but is not making such a change in this amendment. The impact of such a change is so large that it would necessitate its own notice and comment period. Also, as stated previously, HHSC believes that using a single HSL methodology across all of the related programs is prudent. Thus, HHSC would not adopt such a methodology for the UC program alone. In addition, even if HHSC were to make such a change in rule for the UC program only, the 1115 waiver would have to be amended in order to allow for a different methodology in the UC program. No changes were made in response to this comment.

Comment: One commenter requested that HHSC eliminate the secondary reconciliation described in §355.8201(i)(3). They argue that the procedure is not mandated in the 1115 waiver and that the harms to hospitals outweigh the policy benefits.

Response: HHSC is evaluating potential solutions to this issue but is not prepared to adopt a solution at this point. HHSC anticipates continued dialogue and may propose amendments on this issue at a later date. No changes were made in response to this comment.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to

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

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

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.

(a) Introduction. Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver payments are available under this section for services provided between October 1, 2017 and September 30, 2019, by eligible hospitals described in subsection (c) of this section. Waiver payments to hospitals for uncompensated charity care provided beginning October 1, 2019, are described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care). Waiver payments to hospitals must be in compliance with the Centers for Medicare & Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions and this section.

(b) Definitions.

(1) 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 hospital--A hospital enrolled as a Medicaid provider that is:

(A) located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or

(B) designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH); or

(C) designated by Medicare as a Rural Referral Center (RRC) and is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget, or is located in an MSA but has 100 or fewer beds.

(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) Urban rural referral center--A hospital designated by Medicare as a Rural Referral Center (RRC) that is located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget, and that has more than 100 beds.

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

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

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

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

(B) A hospital must notify HHSC Rate Analysis Department 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 on a schedule to be determined by HHSC and posted on HHSC's website.

(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) Set-aside amounts. HHSC will determine set-aside amounts as follows:

(i) For small public hospitals:

(I) that are also rural hospitals:

(-a-) 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.

(-b-) Determine the small rural public hospital set-aside amount by multiplying the value from item (-a-) of this subclause by the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all small rural public 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.

(II) that are also urban RRCs, for DY 7 only, determine the small public urban RRC set-aside amount by multiplying by 54% the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all small public urban RRCs that are eligible to receive uncompensated-care payments under this section and that meet the definition of an urban RRC from subsection (b)(26) of this section. Truncate the resulting value to zero decimal places.

(ii) For private hospitals:

(I) that are also rural hospitals:

(-a-) 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.

(-b-) Determine the private rural hospital set-aside amount by multiplying the value from item (-a-) of this subclause by the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all private rural 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.

(II) that are also urban RRCs, for DY 7 only, determine the private urban RRC set-aside amount by multiplying by 54% the sum of the interim hospital specific limits from subsection (g)(2)(A) of this section for all private urban RRCs that are eligible to receive uncompensated-care payments under this section and that meet the definition of an urban RRC from subsection (b)(26) of this section. Truncate the resulting value to zero decimal places.

(iii) Determine the total set-aside amount by summing the results of subclauses (i)(I), (i)(II), (ii)(I), and (ii)(II) of this subparagraph.

(C) Non-state-owned provider pools. HHSC will allocate the remaining available uncompensated-care funds, if any, and the 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 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 and non-urban RRC 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 and non-urban RRC 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.

(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; and

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

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

(B) Unless otherwise instructed in the application, 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.

(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 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 subclause (f)(2)(B)(i)(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 and non-urban RRC 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 and non-urban RRC hospitals in the pool resulting from subparagraphs (A) - (E) of this paragraph.

(G) 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 urban RRC is guaranteed a payment at least equal to its interim hospital specific limit from paragraph (2)(A) of this subsection multiplied by 54% 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 and non-urban RRC 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 and non-urban RRC 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. HHSC will reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments, if any, made to the hospital for the same period:

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

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

(3) 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.

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

(j) Recoupment.

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