



TO: Medical Care Advisory Committee
DATE: May 17, 2018
FROM: Selvadas Govind
Director of Rate Analysis

Agenda Item No.: 5

SUBJECT: Waiver Payments to Providers for Uncompensated Charity Care

Amendments to: In Chapter 355, Subchapter J, HHSC proposes the following new and amended rules: Division 11, new §355.8208, concerning Waiver Payments to Publicly-Owned Dental Providers for Uncompensated Charity Care; new §355.8210, concerning Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care; new §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care; and new §355.8214, concerning Waiver Payments to Physician Group Practices for Uncompensated Charity Care; amendments to §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care; and amendments to §355.8202, concerning Waiver Payments to Physician Group Practices for Uncompensated Care; Division 23, amendments to §355.8441, concerning Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services; and Division 31, amendments to §355.8600, concerning Reimbursement Methodology for Ambulance Services.

BACKGROUND: Federal Requirement Legislative Requirement Other: Waiver Requirement

On December 21, 2017, the Centers for Medicare & Medicaid Services (CMS) approved the state's request to extend Texas' section 1115(a) demonstration waiver project, entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project Number 11-W-00278/6).

The terms of the waiver extension revise the definition of eligible uncompensated-costs that may be reimbursed from the waiver uncompensated-care pool beginning in demonstration year (DY) 9.¹ Currently, payments from the waiver uncompensated-care pool may reimburse providers for their actual uncompensated cost of medical services that meet the definition of medical assistance contained in section 1905 of the Social Security Act (*i.e.*, Medicaid-covered services) that are provided to Medicaid eligible or uninsured individuals by hospitals, physician group

¹ The current definition of uncompensated costs remains in effect for DYs 7-8.

practices, governmental ambulance providers, and publicly-owned dental providers. Starting October 1, 2019 (DY 9), payments from this pool may only reimburse providers for their actual uncompensated cost of medical services that are provided to individuals as charity care. Charity care includes full or partial discounts provided to patients who meet the provider's charity-care policy and that adhere to the charity-care principles of the Healthcare Financial Management Association.

Additionally, the terms of the waiver extension require the state to ensure that uncompensated-care payments are distributed based on uncompensated cost, without any relationship to source of non-federal share. This is a new limitation on the methodology the state can use to distribute waiver uncompensated-care payments.

HHSC is proposing the new payment rules to implement the revised definitions of eligible uncompensated costs and funding requirements contained in the approved waiver extension.

In addition, the proposed new §355.8012 (concerning waiver payments to hospitals) contains the following changes from the current methodology:

(1) HHSC proposes eliminating the Rider 38 set aside, since under the proposed methodology rural hospitals may receive up to 100% of their eligible uncompensated charity-care costs. If the methodology results in a reduction of reimbursement for the total costs incurred by rural hospitals for providing services to Medicaid beneficiaries and the uninsured (including Medicaid payments and supplemental payments for the hospital's Medicaid shortfall and uninsured non-charity-care costs), HHSC will work with the hospitals to identify other programs through which funding for such uncompensated costs may be increased.

(2) HHSC proposes eliminating the requirement that a secondary reconciliation be performed for hospitals that submitted a request for an adjustment to the interim hospital-specific limit, as described in §355.8201(i)(2). This proposed change is in response to requests from stakeholders.

(3) HHSC proposes eliminating the penalty for failure to complete Category 4 reporting requirements for Regional Healthcare Partnerships. This change is proposed to reduce the burden on hospitals and for administrative convenience.

Since the methodologies described in the current rules will remain in effect for services provided through September 30, 2019, HHSC is proposing amendments to the existing rules to clarify an end date to the methodologies described in those rules. At a later time, HHSC will propose the repeal of §§355.8201 and 355.8202 and amendments to §§355.8441

and 355.8600 to remove obsolete language.

ISSUES AND ALTERNATIVES:

The change in methodology will result in some providers receiving more UC funds than they receive under the current methodology, while others will receive less, depending on how the shift from Medicaid and uninsured costs to charity costs impacts each provider. In the aggregate, there may be significant shifts in the percentages of UC funds that are allocated to each provider type or UC pool.

The shift in distribution between provider types, as well as within a provider type (*e.g.*, between public and private hospitals, or between urban and rural hospitals), may be substantial. However, HHSC has no alternative to implementing the definition of eligible uncompensated costs contained in the terms of the approved waiver extension. For that reason, if the proposed new rules result in a significant reduction of reimbursement to certain provider types or groups, HHSC proposes working with stakeholders to identify other programs through which funding for uncompensated costs incurred by those providers may be increased.

STAKEHOLDER INVOLVEMENT:

HHSC has involved all provider types eligible for reimbursement from the waiver UC pool in discussions of the changes in UC reimbursement since at least January, 2018--just weeks after the waiver extension terms were approved by CMS. Stakeholders were notified in multiple meetings and conference calls of the changes in eligible uncompensated costs, the restrictions on funding, and other terms that will impact reimbursement beginning in DY 9. In March, all provider types, through their associations and other representatives, received the draft UC Protocol that describes in detail the eligible costs and distribution methodologies, and were given opportunities to provide feedback on the protocol. The proposed rules closely mirror the information contained in the draft protocol.

FISCAL IMPACT:

No Yes

RULE DEVELOPMENT SCHEDULE:

May 2018	Present to Hospital Payment Advisory Committee
May 2018	Present to the Medical Care Advisory Committee
May 2018	Present to HHSC Executive Council
July 2018	Publish proposed rules in Texas Register
January 2019	Publish adopted rules in Texas Register
February 2019	Effective date

REQUESTED ACTION: (Check appropriate box)

The MCAC recommends approval of the proposed rules for publication.

Information Only

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
DIVISION 23	EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)
DIVISION 31	AMBULANCE SERVICES

PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes new §355.8208, concerning Waiver Payments to Publicly-Owned Dental Providers for Uncompensated Charity Care; §355.8210, concerning Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care; §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care; and §355.8214, concerning Waiver Payments to Physician Group Practices for Uncompensated Charity Care. HHSC also proposes amendments to §355.8441, concerning Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services; §355.8600, concerning Reimbursement Methodology for Ambulance Services; §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care; and §355.8202, concerning Waiver Payments to Physician Group Practices for Uncompensated Care. The new rules and amendments are necessary to implement revised definitions of eligible uncompensated costs and funding requirements contained in the state's approved Section 1115 waiver extension.

BACKGROUND AND PURPOSE

On December 21, 2017, the Centers for Medicare & Medicaid Services (CMS) approved the state's request to extend Texas' section 1115(a) demonstration waiver project, entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project Number 11-W-00278/6).

For uncompensated-care payments attributable to services provided before October 1, 2019, the current payment and funding methodologies remain in effect. For uncompensated-care payments attributable to services provided after October 1, 2019, the terms of the extension: (1) revise the current definition of eligible uncompensated-care costs that may be reimbursed through the waiver uncompensated-care pool; and (2) require that payment

amounts be unrelated to the source of the non-federal share of the payments.

The terms of the waiver extension also require that the state publish the final administrative rules describing the revised payment methodologies no later than January 30, 2019. Failure to comply with this requirement will result in a reduction in funding for uncompensated-care payments.

To avoid confusion during the lengthy period between publication of the final rules in January, 2019 and the date HHSC implements the revised methodologies in October of that year, HHSC is proposing new rules that will govern the revised payment and funding methodologies. The existing rules will continue to govern payments made before the new methodologies go into effect. HHSC is proposing amendments to the existing rules to clarify an end date to the methodologies described in those rules. At a later time, HHSC will propose the repeal of §§355.8201 and 355.8202 and amendments to §§355.8441 and 355.8600 to remove obsolete language.

OVERVIEW OF CHANGES FROM CURRENT METHODOLOGIES

Currently, payments from the waiver uncompensated-care pool may be used to defray the actual uncompensated cost of medical services that meet the definition of medical assistance contained in section 1905(a) of the Social Security Act that are provided to Medicaid eligible or uninsured individuals by hospitals, physician group practices, governmental ambulance providers, and publicly-owned dental providers. Starting October 1, 2019, payments from this pool may be used to defray the actual uncompensated cost of medical services that are provided to individuals as charity care. Charity-care includes full or partial discounts provided to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association (available at <http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589>).

Additionally, the methodology used by the state to determine uncompensated-care payments must ensure that payments are distributed based on uncompensated cost, without any relationship to source of non-federal share.

HHSC is proposing the new payment rules to implement the revised definitions of eligible uncompensated costs and funding requirements contained in the approved waiver extension.

In addition, the proposed new §355.8212 contains the following changes from the current methodology described in §355.8201:

(1) HHSC proposes eliminating the Rider 38 set aside, since under the proposed methodology rural hospitals may receive up to 100% of their eligible uncompensated charity-care costs. If the methodology results in a reduction of reimbursement for the total costs incurred by rural hospitals for providing services to Medicaid beneficiaries and the uninsured (including Medicaid payments and supplemental payments for the hospital's Medicaid shortfall and uninsured non-charity-care costs), HHSC will work with the hospitals to identify other programs through which funding for such uncompensated costs may be increased.

(2) HHSC proposes eliminating the requirement that a secondary reconciliation be performed for hospitals that submitted a request for an adjustment to the interim hospital-specific limit, as described in §355.8201(i)(2). This proposed change is in response to requests from stakeholders.

(3) HHSC proposes eliminating the penalty for failure to complete Category 4 reporting requirements for Regional Healthcare Partnerships. This change is proposed to reduce the burden on hospitals and for administrative convenience.

SECTION-BY-SECTION SUMMARY

Proposed new §355.8208, Waiver Payments to Publicly-Owned Dental Providers for Uncompensated Charity Care, describes the eligibility requirements for publicly-owned dental providers to receive payments from the waiver uncompensated-care pool and the methodology for calculating payment amounts.

Subsection (a) introduces the rule.

Subsection (b) defines terms used in the rule.

Subsection (c) describes eligibility criteria for receiving a payment under this section.

Subsection (d) limits the sources for funding the non-federal share of payment to public funds from governmental entities.

Subsection (e) describes payment frequency.

Subsection (f) describes limitations on total funding amounts.

Subsection (g) describes the methodology for calculating uncompensated-care maximum payment amounts.

Subsection (h) describes the payment methodology.

Subsection (i) describes the process HHSC will use to recoup any overpayments to the provider.

Proposed amended §355.8441, Reimbursement Methodology for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services, limits application of the section describing supplemental payments to dental providers to services provided through September 30, 2019.

Subsection (a)(1)-(10): no changes are proposed.

Subsection (a)(11)(C) limits application of the subparagraph to services provided through September 30, 2019, and directs the reader to section 355.8208 of the title for a description of the methodology that will apply for services provided after that date.

Subsection (a)(12) - (b): no changes are proposed.

Proposed new §355.8210, Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care, describes the eligibility requirements for governmental ambulance providers to receive payments from the waiver uncompensated-care pool and the methodology for calculating payment amounts.

Subsection (a) introduces the rule.

Subsection (b) defines terms used in the rule.

Subsection (c) describes eligibility criteria for receiving a payment under this section.

Subsection (d) limits the sources for funding the non-federal share of payment to public funds from governmental entities.

Subsection (e) describes payment frequency.

Subsection (f) describes limitations on total funding amounts.

Subsection (g)(1) describes the use of cost reports to document actual costs incurred by the provider and specifies deadlines for submission and other requirements related to the cost reports.

Subsection (g)(2) describes the methodology for calculating uncompensated-care maximum payment amounts.

Subsection (g)(3) describes the methodology used to ensure that total payments to providers in the pool stay within aggregate limits.

Subsection (h) describes the process HHSC will use to recoup any overpayments to the provider.

Proposed amended §355.8600, Reimbursement Methodology for Ambulance Services, limits application of the section describing supplemental payments to governmental ambulance providers to services provided through September 30, 2019.

Subsection (a) - (b): no changes are proposed.

Subsection (c) proposes limiting application of the subparagraph to services provided through September 30, 2019, and directs the reader to section 355.8210 of the title for a description of the methodology that will apply for services provided after that date. No other changes to the subsection are proposed.

Subsection (d): no changes are proposed.

Proposed new §355.8212, Waiver Payments to Hospitals for Uncompensated Charity Care, describes the eligibility requirements for hospitals to receive payments from the waiver uncompensated-care pool and the methodology for calculating payment amounts.

Subsection (a) introduces the rule.

Subsection (b) defines terms used in the rule.

Subsection (c) describes eligibility criteria for receiving a payment under this section.

Subsection (d) limits the sources for funding the non-federal share of payment to public funds from governmental entities and explains that HHSC will survey the governmental entities that provide public funds for payments

to providers in the pool to determine total funding available to support payments from the pool.

Subsection (e) describes payment frequency.

Subsection (f)(1) limits payments by the maximum aggregate amount of funds allocated to the hospital uncompensated-care pool.

Subsection (f)(2) identifies the seven uncompensated-care pools, describes the providers eligible for reimbursement from each pool, explains the method for determining the amount of funds allocated to each pool, and explains the methodology for determining each pool's aggregate limit.

Subsection (f)(3) limits payments by the availability of funds identified in subsection (d).

Subsection (g)(1) describes the use of uncompensated-care applications to document actual costs incurred by the provider.

Subsection (g)(2) describes the three components used to calculate a hospital's maximum uncompensated-care payment amount.

Subsection (g)(3) defines eligible hospital charity-care costs to be consistent with definitions in schedule S-10 of the CMS 2552-10 cost report and describes the source of the data for hospitals that submit S-10 schedules and hospitals that do not do so.

Subsection (g)(4) describes costs, other than inpatient and outpatient charity-care costs, that a hospital may claim for reimbursement from the hospital uncompensated-care pool.

Subsection (g)(5) describes adjustments the hospital may request to the cost and payment data on the hospital's cost report used to calculate interim payment amounts.

Subsection (g)(6) describes the methodology used to ensure that total payments to providers in the pool stay within aggregate limits.

Subsection (g)(7) prohibits duplication of costs.

Subsection (g)(8) describes the methodology for calculating advance payment amounts.

Subsection (h) describes the payment methodology, including the contents of the notice HHSC will provide prior to making payments under this section, the methodology for determining payments if governmental entities transfer less than the amount necessary to fully fund hospitals in the pool, and the final payment opportunity for the demonstration year.

Subsection (i) describes the process HHSC will use to reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments made to the hospital for the same period.

Subsection (j) describes the process to recoup any overpayments to the provider.

Proposed amendments to §355.8201, Waiver Payments to Hospitals for Uncompensated Care, clarify that the rule applies only for services provided through September 30, 2019. The proposed amendment also clarifies that applications are no longer used in the reconciliation process and removes references to transition payments, which were only available during the first demonstration year.

Subsection (a) introduces the rule and proposes to limit application of the rule to services provided through September 30, 2019.

Subsection (b): no changes are proposed.

Subsection (c) describes eligibility criteria for receiving a payment under this section. Paragraph (3)(A) removes obsolete language, since applications are no longer used in the reconciliation process.

Subsection (d): no changes are proposed.

Subsection (e) describes payment frequency and proposes revising the rule to post the schedule on HHSC's website.

Subsection (f) describes funding limitations based on the maximum aggregate amount of funds in the hospital uncompensated-care pool and on the availability of non-federal funds. HHSC proposes eliminating references to obsolete language in paragraph (C)(i)(I) and (III).

Subsection (g)(1) describes the uncompensated-care payment application. HHSC proposes removing references to the use of the application for purposes of the reconciliation process.

Subsections (g)(2)-(7) and (h): no changes are proposed.

Subsection (i) describes the process HHSC will use to reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments made to the hospital for the same period. HHSC proposes removing obsolete references to the third demonstration year and to transition payments. HHSC also proposes adding paragraph (4) to require all hospitals that received a payment during the demonstration year to cooperate in the reconciliation process, even if the hospital closed or withdrew from participation in the program.

Subsection (j): no changes are proposed.

Proposed new §355.8214, *Waiver Payments to Physician Group Practices for Uncompensated Charity Care*, describes the eligibility requirements for certain physician group practices to receive payments from the waiver uncompensated-care pool and the methodology for calculating payment amounts.

Subsection (a) introduces the rule.

Subsection (b) defines terms used in the rule.

Subsection (c) describes eligibility criteria for receiving a payment under this section.

Subsection (d) limits the sources for funding the non-federal share of payment to public funds from governmental entities and explains that HHSC will survey the governmental entities that provide public funds for payments to providers in the pool to determine total funding available to support payments from the pool.

Subsection (e) describes payment frequency.

Subsection (f)(1) limits payments by the maximum aggregate amount of funds allocated to the physician group practice uncompensated-care pool, as described in §355.8212.

Subsection (f)(2) limits payments by the availability of funds identified in subsection (d).

Subsection (g)(1) describes the use of uncompensated-care applications to document actual costs incurred by the provider.

Subsection (g)(2) describes the components used to calculate provider's maximum uncompensated-care payment amount.

Subsection (g)(3) describes adjustments the provider may request to the cost and payment data used to calculate interim payment amounts.

Subsection (g)(4) describes the methodology used to ensure that total payments to providers in the pool stay within aggregate limits.

Subsection (g)(5) describes the methodology for calculating advance payment amounts.

Subsection (h) describes the payment methodology, including the contents of the notice HHSC will provide prior to making payments under this section and the methodology for determining payments if governmental entities transfer less than the amount necessary to fully fund providers in the pool.

Subsection (i) describes the process HHSC will use to reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments made to the hospital for the same period.

Subsection (j) describes the process to recoup any overpayments to the provider.

Proposed amendments to §355.8202, Waiver Payments to Physician Group Practices for Uncompensated Care, clarify that the rule applies only for services provided through September 30, 2019, and clarifies the payments schedule.

Subsection (a) introduces the rule and proposes to limit application of the rule to services provided through September 30, 2019.

Subsections (b) - (d): no changes are proposed.

Subsection (e) describes payment frequency and proposes posting the schedule on HHSC's website.

Subsections (f) - (j): no changes are proposed.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years that the sections will be

in effect, there will be no fiscal implications to state government as a result of enforcing and administering the sections as proposed.

The new methodology that will be implemented for UC will have both a positive and negative impact on the revenues that publicly owned hospitals, physician groups, and ambulance and dental providers will receive for their uncompensated cost of care each year. The impact to local governments will also be positive and negative, depending on the providers in their area and to what extent the local government is responsible for funding the non-federal share of the UC payment. This impact will vary depending on how the uncompensated cost of care for patients classified as charity care patients differ from the uncompensated cost of care for Medicaid and uninsured patients that UC payment amounts were previously based on. HHSC lacks data to provide an estimate of the change in UC payments amounts for specific local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the section(s) will be in effect:

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

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Greta Rymal, Deputy Executive Commissioner for Financial Services, has also determined that there is a possibility for adverse economic impacts to rural communities.

The change in methodology from reimbursing uncompensated cost of care for Medicaid and uninsured patients to reimbursing uncompensated cost of care for charity patients for hospital and non-hospital providers will affect the reimbursement to healthcare providers in communities around the state.

Some hospitals located in rural communities have informed HHSC they do not have the ability to adequately record their charity care charges and costs. It is possible that without complete records of charity care, these rural hospitals might experience lower reimbursement with the change in reimbursement methodology. HHSC lacks data to provide an estimate of the fiscal impact in the rural communities where these hospitals are located.

There will be no adverse economic effect on small businesses or micro-businesses. There are no providers eligible for uncompensated-care payments that meet the definition of a small business or micro-business.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There is a possibility of a negative impact on local employment in some communities and a positive impact in others. The change in methodology from reimbursing uncompensated cost of care for Medicaid and uninsured patients to reimbursing uncompensated cost of care for charity patients for hospital and non-hospital providers will affect the reimbursement to healthcare providers in communities around the state. Certain providers will receive greater reimbursement while others will receive less, depending on the shift in their cost of uncompensated care when calculated using patients who qualify for the providers' charity care policy instead of Medicaid and uninsured patients.

The change in payment amounts will affect revenue received by the healthcare provider, as well as the amount of local and state dollars needed as the non-federal share of the payments. HHSC lacks sufficient data at this time both to predict those communities in which there may be an employment impact and to determine the potential impacts on local employment in those communities.

COSTS TO REGULATED PERSONS

Texas Government Code, §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and is necessary to receive a source of federal funds or comply with federal law.

PUBLIC BENEFIT

Selvadas Govind, Director of Rate Analysis, has determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the sections. The public benefit anticipated as a result of enforcing or administering the sections will be that local communities and private providers will continue to receive federal matching funds for some

uncompensated costs of services provided to charity-care patients, which would not otherwise be available. The public will also benefit from a better understanding of the policies and methodologies governing payment calculations.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

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 COMMENT

Written comments on the proposal may be submitted to Mariah Ramon, Project Manager, P.O. Box 149030, Mail Code H-100, Austin, Texas 78714-9030, or street address 4900 North Lamar Blvd., Austin, Texas 78751; or emailed to uctools@hhsc.state.tx.us.

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) e-mailed by midnight on the last day of the comment period. When e-mailing comments, please indicate "Comments on Proposed Rule 18R034" in the subject line.

STATUTORY AUTHORITY

The amendments and new sections are authorized by 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 amendments and new sections affect Human Resources Code Chapter 32 and Government Code Chapters 531.

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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Legend:

Single Underline = Proposed new language

~~[Strikethrough and brackets]~~ = Current language proposed for deletion

Regular print = Current language

(No change.) = No changes are being considered for the designated subdivision

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 through 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) (No changes.)

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

(1) - (2) (No changes.)

(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 cooperate in the reconciliation process as described in

subsection (i) [~~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 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 [~~as follows and~~] on a schedule to be determined by HHSC and posted on HHSC's website. [÷]

~~[(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) (No changes.)

(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) - (B) (No changes.)

(C) Non-state-owned provider pools. HHSC will allocate the remaining available uncompensated-care funds, if any, and the 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 Rider 38 set-aside amount from subparagraph (B) of this paragraph.

(i) - (ii) (No changes.)

(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; 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. ~~[and]~~

~~[-c-] for the third demonstration year only, add \$136,309,422.]~~

(II) (No changes.)

(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. ~~[and]~~

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

(IV) - (VI) (No changes.)

(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. [÷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) (No changes.)

~~[(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) - (7) (No changes.)

(h) (No changes.)

(i) Reconciliation. HHSC will ~~[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 demonstration ~~[data]~~ year with uncompensated-care payments, if any, made to the hospital for the same period:

(1) - (2) (No changes.)

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

(3) ~~[(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) - (B) (No changes.)

(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) - (k) (No changes.)

§355.8202. Waiver Payments to Physician Group Practices for Uncompensated Care.

(a) Introduction. Payments are available under this section for services provided through September 30, 2019, by an eligible physician group practice described in subsection (c) of this section. Waiver payments to physician group practices for uncompensated charity care provided beginning October 1, 2019, are described in §355.8214 of this division (relating to Waiver Payments to Physician Group Practices for Uncompensated Charity Care). Waiver payments to an eligible physician group practice must be in compliance with the Centers for Medicare and Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions, and this section.

(b) - (d) (No changes.)

(e) Payment frequency. HHSC will distribute waiver payments ~~[as follows and]~~ on a schedule to be determined by HHSC and posted on HHSC's website. [÷]

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

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

(f) - (j) (No changes.)

§355.8208. Waiver Payments to Publicly-Owned Dental Providers for Uncompensated Charity Care.

(a) Introduction. Beginning October 1, 2019, Texas Healthcare Transformation and Quality Improvement 1115 Waiver payments are available under this section for eligible publicly-owned dental providers to help defray the uncompensated cost of charity care. Waiver payments to publicly-owned dental providers for uncompensated care provided before October 1, 2019, are described in §355.8441 of this subchapter (relating to Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services).

(b) Definitions.

(1) 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.

(2) Charity care--Healthcare services provided without expectation of reimbursement to individuals who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association. Charity care includes full or partial discounts given to individuals who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

(3) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made.

(4) 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.

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

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

(7) 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.

(8) Publicly-owned dental provider--A dental provider that uses paid government employees to provide dental services directly funded by a governmental entity.

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

(10) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (2) of this subsection.

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

(c) Eligibility. To be eligible for payments under this section, a publicly-owned dental provider must submit to HHSC an acceptable 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.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities.

(e) Payment frequency. HHSC will distribute uncompensated-care payments on a schedule to be determined by 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 as described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care). If payments for uncompensated care for the publicly-owned dental provider 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)(3) of this section.

(2) 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 all publicly-owned dental providers are

eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Uncompensated-care application. Payments to eligible publicly-owned dental providers are based on cost and payment data reported by the provider on an application form prescribed by HHSC and on supporting documentation. Providers must certify that uncompensated-care costs reported on the application have not been claimed on any other application or cost report.

(2) Calculation. A dental provider's annual maximum uncompensated-care payment amount is calculated as follows:

(A) As detailed in the cost report instructions, the provider must report their charges associated with charity-care services and any payments attributable to those services.

(B) A cost-to-billed-charges ratio will be used to calculate total allowable cost.

(C) The result of subparagraph (B) of this paragraph will be reduced by any related payments to determine the provider's annual maximum uncompensated-care payment amount.

(3) Reduction to stay within the publicly-owned dental provider uncompensated-care pool aggregate limits. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the publicly-owned dental provider pool to exceed the aggregate limit for the pool and will reduce the maximum uncompensated-care payment amounts for each provider in the pool by the same percentage as required to remain within the pool aggregate limit.

(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 each publicly-owned dental provider in the pool;

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

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to providers in the pool will be determined based on the amount of funds transferred by the governmental entities as follows:

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

(B) If the governmental entities do not transfer the maximum amount referenced in paragraph (1) of this subsection, each provider in the pool will receive a portion of its payment amount for that period, based on the provider's percentage of the total payment amounts for all providers in the pool.

(i) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a provider'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 provider will be returned to the entity that owns or is affiliated with the provider.

(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 of the 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 provider against which any overpayment was made or disallowance was directed.

(B) If, within 30 days of the provider's receipt of HHSC's written notice of recoupment, the provider 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 provider until HHSC has recovered an amount equal to the amount overpaid or disallowed.

§355.8210. Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care.

(a) Introduction. Beginning October 1, 2019, Texas Healthcare Transformation and Quality Improvement 1115 Waiver payments are available under this section for eligible governmental ambulance providers to help defray the uncompensated cost of charity care. Waiver payments to governmental ambulance providers for uncompensated care provided before October 1, 2019, are described in §355.8600 of this subchapter (relating to Reimbursement Methodology for Ambulance Services).

(b) Definitions.

(1) 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.

(2) Certified public expenditure (CPE)--An expenditure certified by a governmental entity to represent its contribution of public funds in providing services that are eligible for federal matching Medicaid funds.

(3) Charity care--Healthcare services provided without expectation of reimbursement to individuals who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association. Charity care includes full or partial discounts given to individuals who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

(4) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made.

(5) 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.

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

(7) 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.

(8) Governmental ambulance provider--An ambulance provider that uses paid government employees to provide ambulance services. The ambulance services must be directly funded by a governmental entity. A private ambulance provider under contract with a governmental entity to provide ambulance services is not considered a governmental ambulance provider for the purposes of this section.

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

(10) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (3) of this subsection.

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

(c) Eligibility.

(1) A governmental ambulance provider must submit a written request for eligibility for supplemental payment in a form prescribed by HHSC to the HHSC Rate Analysis Department by a date specified each year by HHSC. An acceptable request must include:

(A) an overview of the governmental agency;

(B) a complete organizational chart of the governmental agency;

(C) a complete organizational chart of the ambulance department within the governmental agency providing ambulance services;

(D) an identification of the specific geographic service area covered by the ambulance department, by ZIP code;

_____ (E) copies of all job descriptions for staff types or job categories of staff who work for the ambulance department and an estimated percentage of time spent working for the ambulance department and for other departments of the governmental agency;

_____ (F) a primary contact person for the governmental agency who can respond to questions about the ambulance department; and

_____ (G) a signed letter documenting the governmental ambulance provider's voluntary contribution of non-federal funds.

_____ (2) If eligible, a governmental ambulance provider may begin to claim uncompensated-care costs related to services provided on or after the first day of the month after the request for eligibility is approved.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will survey the governmental entities that provide public funds for the governmental ambulance providers in the pool to determine the amount of funding available to support payments from that pool.

(e) Payment frequency. HHSC will distribute uncompensated-care payments on a schedule to be determined by 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 as described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care). If payments for uncompensated care for the governmental ambulance provider 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)(3) of this section.

_____ (2) 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 all governmental ambulance providers are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Cost reports. Governmental ambulance providers that are eligible for supplemental payments must submit an annual cost report for ground, water, and air ambulance services delivered to individuals who meet the provider's charity-care policy.

(A) The cost report form will be specified by HHSC. Providers certify through the cost report process their total actual federal and non-federal costs and expenditures for the cost reporting period.

(B) Cost reports must be completed for the full demonstration year for which payments are being calculated. HHSC may require a newly eligible provider to submit a partial-year cost report for their first year of eligibility. The beginning date for the partial-year cost report is the provider's first day of eligibility for supplemental payments as determined by HHSC. The ending date of the partial-year cost report is the last day of the demonstration year that encompasses the cost report beginning date.

(C) The cost report is due on or before March 31 of the year following the cost reporting period ending date and must be certified in a manner specified by HHSC.

(i) If March 31 falls on a federal or state holiday or weekend, the due date is the first working day after March 31.

(ii) A provider may request in writing an extension of up to 30 days after the due date to submit a cost report. HHSC will respond to all written requests for extensions, indicating whether the extension is granted. HHSC must receive a request for extension before the cost report due date. A request for extension received after the due date is considered denied.

(iii) A provider whose cost report is not received by the due date or the HHSC-approved extended due date is ineligible for supplemental payments for the federal fiscal year.

(iv) The individual who completes the cost report on behalf of the provider ("the preparer") must complete the state-sponsored cost report training every other year for the odd-year cost report in order to receive credit to complete both that odd-year cost report and the following even-year cost report. If a new preparer wishes to complete an even-year cost report and has not completed the previous odd-year cost report training, to receive training credit to complete the even-year cost report, the preparer

must complete an even-year cost report training. No exemptions from the cost report training requirements will be granted.

(D) A cost report documents the provider's actual allowable charity-care costs for delivering ambulance services in accordance with the applicable state and federal regulations. Because the cost report is used to determine supplemental payments, a provider must submit a complete and acceptable cost report to be eligible for a supplemental payment.

(E) The uncompensated-care payment is contingent upon the governmental ambulance provider's CPEs related to charity-care services. There are two CPE forms that must be submitted with each cost report:

(i) The cost report certification form formally acknowledges that the cost report is true, correct, and complete, and was prepared in accordance to all applicable rules and regulations.

(ii) The certification of funds form acknowledges that the claimed expenditures are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act, and in accordance with all procedures, instructions, and guidance issued by the single state agency and in effect during the cost report federal fiscal year.

(2) Calculation. An ambulance provider's annual maximum uncompensated-care payment amount is calculated as follows:

(A) As detailed in the cost report instructions, a provider must report their charges associated with charity-care services and any payments attributable to those services.

(B) A provider's total allowable reported costs for ambulance services are allocated to charity-care patients based on the ratio of charges for charity-care patients to the charges for all patients. Only allocable expenditures related to charity care as defined in subsection (b)(3) of this section will be included in calculating the uncompensated-care payment.

(C) The result of subparagraph (B) of this paragraph will be reduced by any related payments reported on the cost report to determine the provider's annual maximum uncompensated-care payment amount.

(3) Reduction to stay within the governmental ambulance provider uncompensated-care pool aggregate limits. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will determine if such a payment would cause

total uncompensated-care payments for the demonstration year for the governmental ambulance provider pool to exceed the aggregate limit for the pool and will reduce the maximum uncompensated-care payment amounts for each provider in the pool by the same percentage as required to remain within the pool aggregate limit.

(h) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a provider's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the federal share of the overpayment or disallowance.

(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 of the 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 provider against which any overpayment was made or disallowance was directed.

(B) If, within 30 days of the provider's receipt of HHSC's written notice of recoupment, the provider 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 provider until HHSC has recovered an amount equal to the amount overpaid or disallowed.

§355.8212. Waiver Payments to Hospitals for Uncompensated Charity Care.

(a) Introduction. Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver payments are available under this section to help defray the uncompensated cost of charity care provided by eligible hospitals on or after October 1, 2019. Waiver payments to hospitals for uncompensated care provided before October 1, 2019, are described in §355.8201 of this division (relating to Waiver Payments to

Hospitals for Uncompensated 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) Charity care--Healthcare services provided without expectation of reimbursement to individuals who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association. Charity care includes full or partial discounts given to individuals who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

(6) Data year--A 12-month period that is described in §355.8066 of this subchapter (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 subchapter.

(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 subchapter (relating to Disproportionate Share Hospital Reimbursement Methodology).

(15) Mid-Level Professional--Medical practitioners which include the following professions only:

___ (A) Certified Registered Nurse Anesthetists;

___ (B) Nurse Practitioners;

___ (C) Physician Assistants;

___ (D) Dentists;

___ (E) Certified Nurse Midwives;

(F) Clinical Social Workers;

(G) Clinical Psychologists; and

(H) 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 (20) 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) Small public hospital--An urban public hospital - Class two or a non-urban public hospital as defined in §355.8065 of this subchapter.

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

(22) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (5) of this subsection.

(23) Uninsured patient--An individual who has no health insurance or other source of third-party coverage for the services provided. The term includes an individual enrolled in Medicaid who received services that do not meet the definition of medical assistance in section 1905(a) of the Social Security Act (Medicaid services), if such inclusion is specified in the hospital's charity-care policy or financial assistance policy and the patient meets the hospital's policy criteria.

(24) 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 be enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year; 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 to the hospital 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, which is posted on HHSC Rate Analysis Department's website for each payment under this section, for the first payment under the affiliation agreement.

(II) Subsequent submissions. The parties must submit revised documentation to HHSC 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 Department's 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 Department 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; and

(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.

(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 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 public funds from governmental entities. 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 survey the governmental entities that provide public funds for the hospitals in that pool to determine the amount of funding available to support payments from that pool.

(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)(6) 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.

(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 the Texas Center for Infectious Disease.

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

(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 unreimbursed charity-care costs 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 to recognize 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 unreimbursed charity-care costs from subsection (g)(2)(A) of this section for all small public hospitals, as defined in subsection (b)(20) of this section, eligible to receive uncompensated-care payments under this section; plus

(-b-) an amount to recognize the IGTs transferred to HHSC by small public hospitals to support DSH payments to themselves for Pass One and Pass Two payments, as described in §355.8065 of this title, for the same demonstration year;

(III) for private hospitals, the sum of the unreimbursed charity-care costs from subsection (g)(2)(A) of this section for all private hospitals, as defined in subsection (b)(16) of this section, eligible to receive uncompensated-care payments under this section;

(IV) for physician group practices, the sum of the unreimbursed charity-care costs calculated as described in §355.8214 of this division (relating to Waiver Payments to Physician Group Practices for Uncompensated Charity Care);

(V) for governmental ambulance providers, the sum of the unreimbursed charity-care costs calculated as described in §355.8210 of this division (relating to Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care), with estimated amounts used if actual data is not available at the time calculations are performed; and

(VI) for publicly-owned dental providers, the sum of the unreimbursed charity-care costs calculated as described in §355.8208 of this division (relating to Waiver Payments to Publicly-Owned Dental Providers), with estimated amounts 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; 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.

(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; 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.

(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; 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.

(IV) Except as outlined in subclause (VII) of this clause, 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) Except as outlined in subclause (VII) of this clause, 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) Except as outlined in subclause (VII) of this clause, 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.

(VII) For demonstration year nine only, the physician group practice pool aggregate limit, the governmental ambulance provider pool aggregate limit, and the publicly owned dental provider pool aggregate limit may not be greater, as a percentage of the applicable total uncompensated-care pool amount, than the amount allocated to each group in demonstration year six.

(3) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section and timely received by HHSC. If sufficient funds are not available for all payments for which the hospitals in each pool are 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 a 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, a 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), a 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) A hospital's annual maximum uncompensated-care payment amount is the sum of the components described in clauses (i) - (iv) of this subparagraph:

(i) the hospital's inpatient and outpatient charity-care costs reported on the uncompensated-care application, as described in paragraph (3) of this subsection;

(ii) other eligible costs for the data year, as described in paragraph (4) of this subsection;

(iii) cost and payment adjustments, if any, as described in paragraph (5) of this subsection; and

(iv) for each large public hospital, the amount transferred to HHSC by that hospital's affiliated governmental entity to support DSH payments for the same demonstration year.

(B) A hospital also participating in the DSH program cannot receive total uncompensated-care payments under this section (related to inpatient and outpatient hospital services provided to uninsured charity-care individuals) and DSH payments that exceed the hospital's total eligible uncompensated costs. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's DSH hospital-specific limit (HSL) plus the unreimbursed costs of non-covered inpatient and outpatient services provided to uninsured charity-care patients.

(3) Hospital charity-care costs. The definitions of eligible hospital charity-care costs are consistent with the definitions contained in schedule S-10 of the CMS 2552-10 cost report.

(A) For each hospital required by Medicare to submit schedule S-10, HHSC will pre-populate the uncompensated-care application described in paragraph (1) of this subsection with reported charity-care charges reported by the hospital on schedule S-10 for the cost reporting period two years before the demonstration year.

(B) For each hospital not required by Medicare to submit schedule S-10 of the CMS 2552-10 cost report, the hospital must report its hospital charity-care charges for the cost reporting period two years before the demonstration year on the uncompensated-care application described in paragraph (1) of this subsection. The definitions of eligible charity-care costs in the application instructions will be consistent with definitions in schedule S-10.

(4) Other eligible costs.

(A) In addition to inpatient and outpatient charity-care costs, a hospital may also claim reimbursement under this section for uncompensated charity care, as specified in the uncompensated-care application, that is related to the following services provided to patients who meet the hospital's charity-care policy:

(i) direct patient-care services of physicians and mid-level professionals; and

(ii) certain pharmacy services.

(B) A 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 subchapter.

(5) Adjustments. When submitting the uncompensated-care application, a hospital 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; and

(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) Notwithstanding the availability of adjustments impacting the cost and payment data described in this section, no adjustments to the interim hospital-specific limit will be considered for purposes of Medicaid DSH payment calculations described in §355.8065 of this subchapter.

(6) 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)(B) 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. 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. 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 this clause and the 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 estimates of available non-federal-share funding upon which the reduction calculations were based are different than actual IGT amounts.

(7) 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.

(8) 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 (6)(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 each hospital in a pool for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

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

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to hospitals in each pool will be determined based on the amount of funds transferred by the affiliated governmental entities as follows:

(A) If the governmental entities transfer the maximum amount referenced in paragraph (1) of this subsection, the hospitals in the pool will receive the full payment amount calculated for that payment period.

(B) If the governmental entities do not transfer the maximum amount referenced in paragraph (1) of this subsection, each hospital in the pool 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 in the pool.

(3) Final payment opportunity. Within payments described in this section, governmental entities that do 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 to hospitals in the pool at the time of the final payment for that demonstration year. The IGT will be applied in the following order:

(A) to the final payments up to the maximum amount; and

(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) 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 of the 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.

§355.8214. Waiver Payments to Physician Group Practices for Uncompensated Charity Care.

(a) Introduction. Beginning October 1, 2019, payments are available under this section to help defray the uncompensated charity-care costs incurred by eligible physician group practices described in subsection (c) of this section. Waiver payments to physician group practices for uncompensated care provided before October 1, 2019, are described in §355.8202 of this division (relating to Waiver Payments to Physician Group Practices for Uncompensated Care). Waiver payments to an eligible physician group practice 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) 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 the physician group practice uncompensated-care pool, as described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care).

(2) 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.

(3) Charity care--Healthcare services provided without expectation of reimbursement to individuals who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association. Charity care includes full or

partial discounts given to individuals who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

(4) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made.

(5) 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.

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

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

(8) Mid-Level Professional--Medical practitioners which include the following professions only:

___ (A) Certified Registered Nurse Anesthetists;

___ (B) Nurse Practitioners;

___ (C) Physician Assistants;

___ (D) Dentists;

___ (E) Certified Nurse Midwives;

___ (F) Clinical Social Workers;

___ (G) Clinical Psychologists; and

___ (H) Optometrists.

(9) 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.

(10) 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.

(11) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (3) of this subsection.

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

(13) Uninsured patient--An individual who has no health insurance or other source of third-party coverage for services, as defined by CMS. The term includes an individual enrolled in Medicaid who received services that do not meet the definition of medical assistance in section 1905(a) of the Social Security Act (Medicaid services), if such inclusion is specified in the hospital's charity-care policy or financial assistance policy and the patient meets the hospital's policy criteria.

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

(c) Eligibility.

(1) A physician group practice is eligible to receive payments under this section if:

(A) it is enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year;

(B) for a private physician group practice only, it has met the submission requirements set forth in §355.8212(c)(1)(B)(iii) of this division, only insofar as that clause relates to certifications, and it files documents with HHSC by the date specified by HHSC, certifying that:

(i) all funds transferred to HHSC as the non-federal share of the waiver payments are public funds; and

(ii) no part of any payment received by the physician group practice under this section will be returned to the governmental entity that transferred to HHSC the non-federal share of the waiver payments;

(C) it has submitted to HHSC an acceptable uncompensated-care physician application for the demonstration year by the deadline specified by HHSC; and

(D) it either:

(i) received a supplemental payment under the Texas Medicaid State Plan for claims adjudicated in one or more months between October 1, 2010, and September 30, 2011; or

(ii) is the successor in a contract to a physician group practice that received a supplemental payment under the Texas Medicaid State Plan for claims adjudicated in one or more months between October 1, 2010, and September 30, 2011.

(2) A physician group practice that fails to submit the required documentation in compliance with this subsection will not receive a payment under this section.

(d) Source of funding.

(1) The non-federal share of funding for payments under this section is limited to and obtained through IGTs from the governmental entities that own or are affiliated with the providers in the physician group practice uncompensated-care pool. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will survey the governmental entities that provide public funds for the physician group practices pool to determine the amount of funding available to support payments from that pool.

(2) An IGT that is not received by the date specified by HHSC may not be accepted.

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

(f) Funding limitations.

(1) Payments made under this section are limited by the maximum aggregate amount of funds allocated to the physician group practice uncompensated-care pool for the demonstration year as described in §355.8212 of this division. If payments for uncompensated care for the physician group practice 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)(4) of this section.

(2) 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 all physician group practices are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Uncompensated-care physician application. Payments to eligible physician group practices are based on cost and payment data reported by the physician group practice on an application form prescribed by HHSC.

(A) Cost and payment data reported by the physician group practice in the uncompensated-care physician 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 physician group practice for a prior period with uncompensated-care waiver payments, if any, made to the practice for the same period. The reconciliation process is more fully described in subsection (j) of this section.

(B) Unless otherwise instructed in the uncompensated-care physician application:

(i) the cost and payment data reported in the uncompensated-care physician application must be consistent with Medicare cost-reporting principles and must comply with the application instructions or other guidance issued by HHSC, and the physician group practice must maintain sufficient documentation to support the reported data or information; and

(ii) the costs associated with an episode of care where a physician group practice is paid under contract must be reduced by any revenues associated with that episode of care prior to inclusion in the uncompensated-care physician application.

(C) If a physician group practice withdraws from participation in the waiver, the practice must submit an uncompensated-care application reporting its actual costs and payments for any period during which the

practice received uncompensated-care payments. The uncompensated-care physician application will be used for the purpose described in subparagraph (A)(ii) of this paragraph. If a practice fails to submit the application reporting its actual costs, HHSC will recoup the full amount of uncompensated-care payments to the practice for the period at issue.

(2) Calculation. A physician group practice's annual maximum uncompensated-care payment amount is the sum of the following components:

(A) its unreimbursed charity-care costs, as reported on the uncompensated-care physician application; and

(B) cost and payment adjustments, if any, as described in paragraph (3) of this subsection.

(3) Adjustments. When submitting the uncompensated-care physician application, physician group practices may request that cost and payment data from the reporting period be adjusted to reflect increases or decreases in costs resulting from changes in operations or circumstances.

(A) A physician group practice may request that:

(i) costs not reflected on the financial documents supporting the application, but which would be incurred for the demonstration year, be included when calculating payment amounts; or

(ii) costs reflected on the financial documents supporting the application, 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 financial documents supporting the application will be incurred for the demonstration year.

(4) Reduction to stay within physician group practice uncompensated-care pool aggregate limits. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year for the physician group practice uncompensated-care pool described in §355.8212 of this division, 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 are limited to the physician group practice uncompensated-care pool.

(B) HHSC will calculate the following data points:

(i) for each provider, prior period payments to equal prior period uncompensated-care 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) 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 member's annual maximum uncompensated-care payment amounts for the demonstration year from paragraph (2) of this subsection; and

(v) a pool-wide ratio calculated as the pool aggregate limit from §355.8212 of this division 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 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.

HHSC will calculate a capped payment amount equal 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. 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 this subparagraph and the 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 estimates of available non-federal-share funding upon which the reduction calculations were based are different than actual IGT amounts.

(5) 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 physician group practices that meet the eligibility requirements described in subsection (c) of this section and submitted an acceptable uncompensated-care physician 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 (4)(B)(i) of this subsection.

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

(E) If a partial year uncompensated-care physician 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.

(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.

(h) Payment methodology.

(1) 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 each physician group practice in the pool for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

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

(C) the deadline for completing the IGT.

(2) The amount of the payment to the physician group practices under paragraph (1) of this subsection will be determined based on the amount of funds transferred by the affiliated governmental entities as described as follows:

(A) If the governmental entities transfer the maximum amount of funds described in paragraph (1)(B) of this subsection, the physician group practices will receive the maximum allowable payment amounts for that period.

(B) If the governmental entities do not transfer the maximum amount referenced in paragraph (1)(B) of this subsection, each physician group practice in the pool will receive a portion of its payment amount for that period, based on the physician group practice's percentage of the total payment amounts for all physician group practices in the pool.

(i) Reconciliation. Data on the uncompensated-care physician application will be used to reconcile actual costs incurred by the physician group practice for a prior period with uncompensated-care payments, if any, made to the physician group practice for the same period.

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

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

(j) Recoupment.

(1) In the event of a disallowance by CMS of federal financial participation related to a physician group practice'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 physician group practice will be returned to the entity that owns or is affiliated with the physician group practice.

(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 of the 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 physician group practice against which any disallowance was directed or to which an overpayment was made.

(B) If, within 30 days of the physician group practice's receipt of HHSC's written notice of recoupment, the physician group practice 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 physician group practice until HHSC has recovered an amount equal to the amount overpaid or disallowed.

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 23 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND
TREATMENT (EPSDT)

§355.8441. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services.

(a) The following are reimbursement methodologies for services provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, delivered to Medicaid clients under age 21, also known as Texas Health Steps (THSteps) and the THSteps Comprehensive Care Program (CCP). Reimbursement methodologies for services provided to all Medicaid clients, including clients under age 21, are located elsewhere in this chapter.

(1) - (10) (No changes.)

(11) Dental services are reimbursed in accordance with the following Medicaid reimbursement methodologies:

(A) Dental services provided by enrolled dental providers are reimbursed in accordance with §355.8085 of this subchapter.

(B) Dental services provided by federally qualified health centers (FQHCs) are reimbursed in accordance with §355.8261 of this subchapter (relating to Federally Qualified Health Center Services Reimbursement).

(C) For services provided through September 30, 2019 [Subject to approval by the Centers for Medicare and Medicaid Services, for services provided on or after March 1, 2012], publicly owned dental providers may be eligible to receive Uncompensated Care (UC) payments for dental services under the Texas Healthcare Transformation and Quality Improvement 1115 Waiver, as described in this section. For services provided beginning October 1, 2019, eligibility for publicly owned dental providers to receive waiver payments, and the methodology for calculating payment amounts, is described in section 355.8208 of this title. For purposes of this section, Uncompensated Care [("UC")] payments are 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. HHSC will calculate UC payments using the following methodology:

(i) - (vi) (No changes.)

(12) (No changes.)

(b) Fees for EPSDT services are adjusted within available funding as described in §355.201 of this title (relating to Establishment and Adjustment of Reimbursement Rates by the Health and Human Services Commission).

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 31 AMBULANCE SERVICES

§355.8600. Reimbursement Methodology for Ambulance Services.

(a) - (b) (No changes.)

(c) Reimbursement methodologies.

(1) Fee-for-service ambulance fee. Fee-for-service reimbursement is based on the lesser of a provider's billed charges or the maximum fee established by the Texas Health and Human Services Commission (HHSC). HHSC establishes fees by reviewing the Medicare fee schedule and analyzing any other available ambulance-related data. Fee-for-service rates apply to both private and governmental ambulance providers.

(2) Supplemental payment for governmental ambulance providers. For services provided through September 30, 2019, a [A] governmental ambulance provider may be eligible to receive a supplemental payment in addition to the fee-for-service payment described in paragraph (1) of this subsection. For services provided beginning October 1, 2019, eligibility for governmental ambulance providers to receive a supplemental payment, and the methodology for calculating the payment amount, are described in section 355.8210 of this chapter.

(A) - (C) (No changes.)

(d) (No changes.)