TO: Medical Care Advisory Committee

DATE: November 12, 2020

FROM: Victoria Grady, Director of Provider Finance

SUBJECT: Uncompensated Care Reconciliation for Demonstration Years 6-8

Agenda Item No.: 11

Amendments to: §355.8201 Waiver Payments to Hospitals for Uncompensated Care

BACKGROUND: ☐ Federal Requirement ☐ Legislative Requirement ☒ Other: (e.g., Program Initiative)

The Texas Health and Human Services Commission proposes to amend Texas Administrative Code Title 1, Part 15, Chapter 355, Subchapter J, Division 11, Section 355.8201, relating to Waiver Payments to Hospitals for Uncompensated Care. The purpose of the proposal is to revise the secondary reconciliation process applied to hospitals that requested an adjustment to their interim hospital-specific limit (HSL) for purposes of calculating uncompensated care (UC) payments in demonstration years (DYs) 6 through 8 (October 1, 2016, to September 30, 2019), and to describe the methodology HHSC will use to redistribute recouped funds. The amendment to the secondary reconciliation is in response to a petition for rulemaking.

As part of the UC application process, a hospital can submit a request for an adjustment to cost and payment data to reflect increases or decreases in costs resulting from changes in operation or circumstance. If a hospital requested an adjustment on its UC application that impacted its interim HSL (now referred to as the state payment cap), it would be subject to an additional reconciliation. The purpose of this secondary reconciliation is to ensure that a hospital that inaccurately adjusts its interim HSL does not benefit from that inaccuracy.

Under the current secondary reconciliation process, HHSC compares a hospital's adjusted interim HSL for the demonstration year to its final HSL for the demonstration year. If the final HSL is less than the adjusted interim HSL, the hospital's UC payment is calculated for the demonstration year using the final HSL instead of the adjusted interim HSL, with no other changes being made to the data used in the original calculation of the hospital's UC payment. HHSC then recoups any payment received by the hospital that is greater than the recalculated payment.

The interim HSL is defined by HHSC and is calculated in the payment year for hospitals that participate in the Disproportionate Share Hospital (DSH) and UC programs. The final HSL is governed by federal law and is calculated two years after the payment year using actual program year data. HHSC's understanding of the federal regulation governing the final HSL has changed since HHSC calculated the

adjusted interim HSL for UC payments in DYs 6 through 8 and will require a different methodology to be used to calculate the final HSL for those years.

As a result, there is a risk that a hospital that submitted a request on its UC application to adjust its interim HSL in DYs 6 through 8 could have a final HSL that is less than its adjusted interim HSL due only to the change in HSL methodology. Under the current secondary reconciliation provision, HHSC would recoup any payment received by the hospital that is greater than the recalculated UC payment.

HHSC proposes to amend §355.8201(i)(3) to revise the secondary reconciliation process applied to hospitals that adjusted their interim HSL in DYs 6 through 8. This proposed change is in response to a petition for rulemaking from Texas Children's Hospital and is intended to prevent recoupments from hospitals that are solely the result of a change in the federal regulation related to the final HSL calculation. For DYs 6 through 8, HHSC proposes to compare a hospital's adjusted interim HSL for the demonstration year to a proxy-final HSL for the demonstration year. The proxy-final HSL will be calculated using the same methodology described in §355.8066(c)(2) for the demonstration year, except that it will not offset third-party and Medicare payments for claims and encounters where Medicaid was a secondary payer. If the proxy-final HSL is less than the adjusted interim HSL, HHSC will recalculate the hospital's UC payment for the demonstration year using the proxy-final HSL.

HHSC proposes to amend §355.8201(k) to describe the methodology HHSC will use to redistribute recouped funds to providers eligible for additional payments. A provider is eligible for an additional payment if it has allowable uncompensated costs that were not reimbursed through its initial UC payment for the demonstration year.

Recouped funds from state providers will be redistributed proportionately to eligible state providers based on the percentage that each eligible state provider's remaining final uncompensated cost of care (UCC) calculated in the reconciliation described in §355.8201(i) is of the total remaining final UCC of all eligible state providers.

Recouped funds from non-state providers will be redistributed proportionately to eligible non-state providers, except for in DYs 7 and 8 (October 1, 2017 to September 30, 2019).

For DYs 7 and 8, recouped funds from non-state providers will be redistributed to eligible non-state providers using a weighted allocation methodology. First, HHSC will calculate a weight that will be applied to all non-state providers. The weight is calculated based on the provider's final remaining UCC with and without the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer to determine how significantly the provider's UCC was impacted by not offsetting these payments. Providers who did not have a significant change in their UCC will receive a larger weight.

Then, HHSC will make a first pass allocation to determine a provider's additional payment amount. HHSC will limit a provider's payment to the amount of the provider's final remaining UCC. If a provider is allocated a payment amount that is higher than its remaining UCC, HHSC will make a second pass allocation to

redistribute the excess funds using the remaining UCC for all non-state providers without applying the weight.

ISSUES AND ALTERNATIVES:

As previously mentioned, HHSC received a petition for rulemaking from Texas Children's Hospital to revise the secondary reconciliation provision to prevent unforeseen and unintended harm to hospitals that requested adjustments to increase their interim HSLs in DYs 6 through 8. It is anticipated that providers that requested these adjustments during the affected years will react positively to the proposed amendment as the changes are intended to prevent recoupments for hospitals that are solely the result of the change in the federal regulation related to the final HSL calculation.

HHSC anticipates stakeholder feedback will vary regarding the methodology to redistribute recouped funds. For state providers, and non-state providers in all DYs except 7 and 8, recouped funds will be redistributed proportionately. For non-state providers in DYs 7 and 8, stakeholder feedback will likely depend on the amount of Medicare and third-party payments a provider had when UC interim payments were calculated. The proposed methodology gives a larger weight to non-state providers that would have been eligible for a higher interim UC payment in DYs 7 and 8 if the payment was offset by Medicare and third-party payments.

STAKEHOLDER INVOLVEMENT:

HHSC received comments from stakeholders and provider representatives regarding the secondary reconciliation provision for DYs 6 through 8 during two previous rule amendments. HHSC declined to make a change during the February 2020 rule amendment because it did not have complete information about the methodology the federal government planned to use for the affected years for auditing purposes. HHSC declined to make a change during the July 2020 rule amendment because it was outside the scope of the proposed change but responded that it would take the comment into consideration for future rule changes.

The proposed rule was presented to the Hospital Payment Advisory Committee on November 5, 2020, as an informational item. The proposal will be presented to the HHSC Executive Council meeting on November 19, 2020. Additionally, HHSC held a public hearing to receive public comments following the publication of the proposed rule.

FISCAL IMPACT:

☒ Yes *(if yes, fill out the following table)*

There is no anticipated fiscal impact on state government.

HHSC does not have sufficient data to determine how specific hospitals would be impacted by this rule amendment.

The proposed rule will have both a positive and negative impact on local governments, depending on the amount of Medicare and third-party payments each

local governmental hospital had. The fiscal impact will not be known until the final UC reconciliation is completed for each of the affected demonstration years.

RULE DEVELOPMENT SCHEDULE:

October 2020	Publish proposed rules in *Texas Register*
November 5, 2020	Present to the Hospital Payment Advisory Committee
November 12, 2020	Present to the Medical Care Advisory Committee
November 19, 2020	Present to HHSC Executive Council
December 2020	Publish adopted rules in *Texas Register*
December 31, 2020	Effective date

REQUESTED ACTION:

☐ 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

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care.

BACKGROUND AND PURPOSE

The purpose of the proposal is to revise the secondary reconciliation process applied to hospitals that requested an adjustment to their interim hospital-specific limit (HSL) for purposes of calculating uncompensated care (UC) payments in demonstration years 6 through 8 (October 1, 2016 to September 30, 2019), and to describe the methodology HHSC will use to redistribute recouped funds. The amendment to the secondary reconciliation process is in response to a petition for rulemaking.

Secondary Reconciliation

As part of the UC application process, a hospital can submit a request for an adjustment to cost and payment data to reflect increases or decreases in costs resulting from changes in operation or circumstance. If a hospital requested an adjustment on its UC application that impacted its interim HSL (now referred to as the state payment cap), it would be subject to an additional reconciliation. The purpose of this secondary reconciliation is to ensure that a hospital that inaccurately adjusts its interim HSL does not benefit from that inaccuracy.

Under the current secondary reconciliation process, HHSC compares a hospital's adjusted interim HSL for the demonstration year to its final HSL for the demonstration year. If the final HSL is less than the adjusted interim HSL, the hospital's UC payment is recalculated for the demonstration year using the final HSL instead of the adjusted interim HSL, with no other changes being made to the data used in the original calculation of the hospital's UC payment. HHSC then recoups any payment received by the hospital that is greater than the recalculated payment.

The interim HSL is defined by HHSC and is calculated in the payment year for hospitals that participate in the Disproportionate Share Hospital (DSH) and UC programs. The final HSL is governed by federal law and is calculated two years after the payment year using actual program year data. HHSC's understanding of the federal regulation governing the final HSL has changed since HHSC calculated the

adjusted interim HSL for UC payments in demonstration years 6 through 8 and will require a different methodology to be used to calculate the final HSL for those years.

As a result, there is a risk that a hospital that submitted a request on its UC application to adjust its interim HSL in demonstration years 6 through 8 could have a final HSL that is less than its adjusted interim HSL due only to the change in HSL methodology. Under the current secondary reconciliation provision, HHSC would recoup any payment received by the hospital that is greater than the recalculated UC payment.

HHSC proposes to amend §355.8201(i)(3) to revise the secondary reconciliation process applied to hospitals that adjusted their interim HSL in demonstration years 6 through 8. This proposed change is in response to a petition for rulemaking from Texas Children's Hospital and is intended to prevent recoupments from hospitals that are solely the result of the change in the federal regulation related to the final HSL calculation. For demonstration years 6 through 8, HHSC proposes to compare a hospital's adjusted interim HSL for the demonstration year to a proxy-final HSL for the demonstration year. The proxy-final HSL will be calculated using the methodology described in §355.8066(c)(2) for the demonstration year, except that it will not offset third-party and Medicare payments for claims and encounters where Medicaid was a secondary payer. If the proxy-final HSL is less than the adjusted interim HSL, HHSC will recalculate the hospital's UC payment for the demonstration year using the proxy-final HSL.

HHSC also proposes other clarifying changes to indicate which demonstration years are subject to the secondary reconciliation process.

Redistribution of Recouped Funds

Under the terms of the Texas Healthcare Transformation and Quality Improvement Program 1115 Medicaid demonstration waiver, HHSC may redistribute recouped funds identified in the reconciliation process to eligible providers if there is available UC funding for the demonstration year. HHSC proposes to amend §355.8201(k) to describe the methodology HHSC will use to redistribute recouped funds to providers eligible for additional payments. A provider is eligible for an additional payment if it has allowable uncompensated costs that were not reimbursed through its initial UC payment for the demonstration year.

Recouped funds from state providers will be redistributed proportionately to eligible state providers based on the percentage that each eligible state provider's remaining final uncompensated cost of care (UCC) calculated in the reconciliation described in §355.8201(i) is of the total remaining final UCC of all eligible state providers.

Recouped funds from non-state providers will be redistributed proportionately to eligible non-state providers, except for in demonstration years 7 and 8 (October 1, 2017 to September 30, 2019). First, HHSC will return the non-federal share portion

of the recouped funds to the governmental entity that provided it during the program year for the eligible providers. Then, the federal share portion of the recouped funds will be redistributed proportionately among all eligible providers that have a source of the non-federal share for the additional payment. If a payment does not have a source of the non-federal share, then the federal share will be returned to the Centers for Medicare & Medicaid Services (CMS).

For demonstration years 7 and 8, recouped funds from non-state providers will be redistributed to eligible non-state providers using a weighted allocation methodology. First, HHSC will calculate a weight that will be applied to all non-state providers. The weight is calculated based on the provider's final remaining UCC with and without the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer to determine how significantly the provider's UCC was impacted by not offsetting these payments. Providers who did not have a significant change in their UCC will receive a larger weight.

After calculating the weighting factor, HHSC will make a first pass allocation by multiplying the weight by the provider's final remaining UCC with the offset of payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer. HHSC will divide the product by the total remaining UCCs for all non-state providers and multiply the quotient by the total amount of recouped dollars available for redistribution. HHSC will limit a provider's payment to the amount of the provider's final remaining UCC. If a provider is allocated a payment amount that is higher than its remaining UCC, HHSC will make a second pass allocation to redistribute the excess funds using the remaining UCC for all non-state providers without applying the weight.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.8201(i)(3) revises the secondary reconciliation process applied to hospitals that requested an adjustment to their interim HSL in demonstration years 6 through 8. The proposed amendment also includes other clarifying changes to indicate which demonstration years are subject to the secondary reconciliation process.

The proposed amendment to §355.8201(k) adds new language to describe the methodology HHSC will use to redistribute recouped funds. The previous language contained in subsection (k) is moved to new §355.8201(l).

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, there are no fiscal implications for state government as a result of enforcing or administering the proposed amendment.

The proposed amendment will have both a positive and negative impact on local governments, depending on the amount of Medicare and third-party payments the

local governmental hospital received. The fiscal impact will not be known until the final UC reconciliation is completed for each of the affected demonstration years.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rule will be in effect:

(1) the proposed rule will not create or eliminate a government program;

(2) implementation of the proposed rule will not affect the number of HHSC employee positions;

(3) implementation of the proposed rule will result in no assumed change in future legislative appropriations;

(4) the proposed rule will not affect fees paid to HHSC;

(5) the proposed rule will not create a new rule;

(6) the proposed rule will not expand, limit, or repeal existing rule;

(7) the proposed rule will not change the number of individuals subject to the rule; and

(8) the proposed rule will not affect the state's economy.

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. There are no Texas hospitals participating in Medicaid that qualify as small businesses or micro-businesses. The proposed rule does not impose any additional fees or costs on rural communities required to comply.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

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.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public benefit will be that certain hospitals will be able to retain UC payments that might otherwise have been

recouped solely due to a change in the federal regulation governing the final HSL calculation.

Trey Wood has also determined that for the first five years the rule is in effect, there is no anticipated economic cost to persons who are required to comply with the proposed rule because the proposed rule does not impose any additional costs or fees on persons required to comply.

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 Texas Government Code §2007.043.

PUBLIC HEARING

Details for the public hearing will be published as a notice in the *Texas Register* at a later date.

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC, Mail Code H400, P.O. Box 13247, Austin, Texas 78711-3247, or by email to RAD_1115_Waiver_Finance@hhsc.state.tx.us.

During the current state of disaster due to COVID-19, physical forms of communication are checked with less frequency than during normal business operations. Therefore, please submit comments by email if possible.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. 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) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 21R012" in the subject line.

STATUTORY AUTHORITY

The amendment is 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; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting

reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code, Chapter 32.

The amendment affects Texas Human Resources Code Chapter 32 and Texas Government Code Chapter 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.

ADDITIONAL INFORMATION

For further information, please call: (512) 407-3285.

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 11 TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT

§355.8201. Waiver Payments to Hospitals for Uncompensated Care.

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

(b) Definitions.

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

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

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

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

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

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

(7) Delivery System Reform Incentive Payments (DSRIP)--Payments related to the development or implementation of a program of activity that supports a hospital's efforts to enhance access to health care, the quality of care, and the

health of patients and families it serves. These payments are not considered patient-care revenue and are not offset against the hospital's costs when calculating the hospital-specific limit as described in §355.8066 of this title.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(24) Uncompensated-care payments--Payments intended to defray the uncompensated costs of services that meet the definition of "medical assistance" contained in §1905(a) of the Social Security Act that are provided by the hospital to Medicaid eligible or uninsured individuals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) Submission requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) submit to HHSC documentation of:

(i) its participation in an RHP; or

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

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

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

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

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

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

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

(e) Payment frequency. HHSC will distribute waiver payments on a schedule to be determined by HHSC and posted on HHSC's website.

(f) Funding limitations.

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

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

(A) The state-owned hospital pool.

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

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

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

(i) For small public hospitals:

(I) that are also rural hospitals:

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

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

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

(ii) For private hospitals:

(I) that are also rural hospitals:

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

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

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

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

(C) Non-state-owned provider pools. HHSC will allocate the remaining available uncompensated-care funds, if any, and the set-aside amount among the non-state-owned provider pools as described in this subparagraph. The remaining available uncompensated-care funds equal the amount of funds approved by CMS for uncompensated-care payments for the demonstration year less the sum of funds allocated to the state-owned hospital pool under subparagraph (A) of this paragraph and the set-aside amount from subparagraph (B) of this paragraph.

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

(I) Large public hospitals:

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

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

(II) Small public hospitals:

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

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

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

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

(V) Governmental ambulance providers: The sum of the uncompensated care costs multiplied by the federal medical assistance percentage (FMAP) in effect during the cost reporting period for governmental ambulance providers, as described in §355.8600 of this title (relating to Reimbursement Methodology for Ambulance Services). Estimated amounts may be used if actual

data is not available at the time calculations are performed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Uncompensated-care payment amount.

(1) Application.

(A) Cost and payment data reported by the hospital in the uncompensated-care application is used to calculate the annual maximum uncompensated-care payment amount for the applicable demonstration year, as described in paragraph (2) of this subsection.

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

(i) When the application requests data or information outside of the as-

filed cost report(s), the hospital must provide all requested documentation to support the reported data or information.

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

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

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

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

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

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

(3) Other eligible costs.

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

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

(ii) pharmacy services; and

(iii) clinics.

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

(4) Adjustments. When submitting the uncompensated-care application,

hospitals may request that cost and payment data from the data year be adjusted to reflect increases or decreases in costs resulting from changes in operations or circumstances.

(A) A hospital:

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

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

(B) Documentation supporting the request must accompany the application. HHSC will deny a request if it cannot verify that costs not reflected on the as-filed cost report will be incurred for the demonstration year.

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

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

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

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

(B) HHSC will calculate the following data points:

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

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

(I) the portion of the annual maximum uncompensated-care payment

amount calculated for that provider (as described in this section and the sections referenced in subsection (f)(2)(C) of this section) that is attributable to the payment period; and

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

(iii) The cumulative maximum payment amount to equal the sum of prior period payments from clause (i) of this subparagraph and the maximum uncompensated-care payment for the payment period from clause (ii) of this subparagraph for all members of the pool combined.

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

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

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

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

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

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

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

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

(iii) If the payment period is the final payment period for the

demonstration year:

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

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

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

(II) HHSC will calculate an IGT-supported maximum uncompensated-care payment for the demonstration year to equal the IGT-supported maximum uncompensated-care payment for the payment period from subclause (I) of this clause plus the provider's prior period payments from subparagraph (B)(i) of this paragraph.

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

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

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

(-a-) For each provider, HHSC will calculate an overage amount to equal the difference between the IGT-supported maximum uncompensated-care payment amount for the demonstration year from subclause (II) of this clause and their capped payment amount for the demonstration year from clause (i) of this

subparagraph. Unfunded cap room from subclause (IV) of this clause will be distributed to these providers based on each provider's overage as a percentage of the pool-wide overage.

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

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

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

(G) Notwithstanding the calculations described in subparagraphs (A) - (E) of this paragraph, if the payment period is the final payment period for the demonstration year, to the extent the payment is supported by IGT, each urban RRC is guaranteed a payment at least equal to its interim hospital specific limit from paragraph (2)(A) of this subsection multiplied by 54% for the demonstration year less any prior period payments. If this guarantee will cause payments for a pool to exceed the aggregate pool limit, the reduction required to stay within the pool limit will be distributed proportionally across all non-rural and non-urban RRC providers in the pool based on each provider's resulting payment from subparagraphs (A) - (E) of this paragraph as compared to the payments to all non-rural and non-urban RRC hospitals in the pool resulting from subparagraphs (A) - (E) of this paragraph.

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

(7) Advance payments.

(A) In a demonstration year in which uncompensated-care payments will be

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

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

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

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

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

(8) Payments of unspent funds.

(A) HHSC will use the methodology described in this paragraph to calculate payment amounts to hospitals for uncompensated-care payments that are made after July 31, 2020, using any remaining funding for uncompensated-care program years beginning before October 1, 2017.

(B) The basis for each hospital's payment allocation will be the total amount of payments received by the hospital in the data year that are from a third-party payor for a Medicaid-enrolled patient and associated with third-party coverage as defined in §355.8066 of this subchapter (relating to Hospital-Specific Limit Methodology).

(C) All hospitals' payment allocations will be based on 100 percent of the amount described in subparagraph (B) of this paragraph, except:

(i) Children's hospitals as defined in §355.8065 of this subchapter (related to Disproportionate Share Hospital Reimbursement Methodology) will receive a payment allocation based on 150 percent of the amount described in subparagraph (B) of this paragraph.

(ii) State-owned teaching hospitals, state-owned IMDs, state chest hospitals, physician group practices, ambulance providers, and dental providers will not receive a payment allocation under the methodology described in this paragraph.

(D) Each hospital's payment amount will be allocated by:

(i) applying the appropriate percentage described in subparagraph (C) of this paragraph to the amount described in subparagraph (B) of this paragraph;

(ii) dividing the amount calculated in clause (i) of this subparagraph by the total amount of payments described in subparagraph (B) of this paragraph for all participating hospitals; and

(iii) multiplying the amount in clause (ii) of this subparagraph by the remaining uncompensated-care funding for the program year.

(E) Each payment amount will be compared to actual costs incurred by the hospital as determined by the reconciliation calculated for the demonstration year, as described in subsection (i) of this section.

(i) A hospital will receive the lesser of its actual costs, as determined by the reconciliation calculated for the demonstration year under subsection (i) of this section, or the hospital's allocation described in subparagraph (D) of this paragraph.

(ii) If, following the determination described in clause (i) of this subparagraph, there is funding remaining in the UC program year, the remaining funding amounts will be placed into a second pool.

(iii) The second pool will be allocated to hospitals that have not received UC payments that exceed their actual costs, as determined by the reconciliation calculated for the demonstration year under subsection (i) of this section after accounting for any additional payment the hospital is receiving under the methodology described in this paragraph. Any distribution under this subparagraph will be allocated by:

(I) Dividing the hospital's total uncompensated-care costs, as determined by the reconciliation calculated for the demonstration year under subsection (i) of this section, by the total uncompensated-care costs for all participating hospitals, as determined by the reconciliation calculated for the demonstration year under subsection (i) of this section; and

(II) Multiplying the amount described in subclause (I) of this clause by the funding remaining in the uncompensated-care program year after the distribution described in subparagraph (D) of this paragraph.

(h) Payment methodology.

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

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

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

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to a hospital will be

determined based on the amount of funds transferred by the affiliated governmental entity or entities as follows:

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

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

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

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

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

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

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

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

(i) Reconciliation. HHSC will reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments, if any, made to the hospital for the same period:

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

(2) If a hospital received payments less than its actual costs, and if HHSC has available waiver funding for the demonstration year in which the costs were

accrued, the hospital may receive reimbursement for some or all of those actual documented unreimbursed costs.

(3) If [~~Except in demonstration year 2 (October 1, 2012, to September 30, 2013), if~~] a hospital submitted a request as described in subsection (g)(4)(A)(i) of this section that impacted its interim hospital-specific limit, HHSC [~~that hospital~~] will conduct [~~be subject to~~] an additional reconciliation for certain demonstration years as follows:

(A) For demonstration years 3-5 (October 1, 2013 – September 30, 2016), HHSC will compare the hospital's adjusted interim hospital-specific limit from subsection (g)(4)(A)(i) of this section for the demonstration year to its final hospital-specific limit as described in §355.8066(c)(2) of this title for the demonstration year.

(B) For demonstration years 6-8 (October 1, 2016 – September 30, 2019), HHSC will compare the hospital's adjusted interim hospital-specific limit from subsection (g)(4)(A)(i) of this section for the demonstration year to a proxy-final hospital-specific limit that is described in §355.8066(c)(2) of this title for the demonstration year, except this proxy-final hospital-specific limit will not offset third-party and Medicare payments for claims and encounters where Medicaid was a secondary payer.

(C) [~~(B)~~] If the final hospital-specific limit for demonstration years 3-5 or proxy-final hospital-specific limit for demonstration years 6-8 limit is less than the adjusted interim hospital-specific limit, HHSC will recalculate the hospital's uncompensated-care payment for the demonstration year substituting the final hospital-specific limit for demonstration years 3-5 or proxy-final hospital-specific limit for demonstration years 6-8 for the adjusted interim hospital-specific limit with no other changes to the data used in the original calculation of the hospital's uncompensated-care payment other than any necessary reductions to the original IGT amount and will recoup any payment received by the hospital that is greater than the recalculated uncompensated-care payment. Recouped funds may be redistributed to other hospitals that received payments less than their actual costs using the methodology described in subsection (k) of this section.

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

(j) Recoupment.

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

recouped from the hospital will be returned to the entity that owns or is affiliated with the hospital.

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

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

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

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

(k) Redistribution of Recouped Funds. Following the recoupments described in subsection (j) of this section, HHSC will redistribute the recouped funds to eligible providers. For purposes of this subsection, an eligible provider is a provider who has room remaining in their final remaining uncompensated cost of care (UCC) calculated in the reconciliation described in subsection (i) of this section after considering all uncompensated-care payments made for that program year. Recouped funds from state providers will be redistributed proportionately to eligible state providers based on the percentage that each eligible state provider's remaining final UCC calculated in the reconciliation described in subsection (i) of this section is of the total remaining final UCC calculated in the reconciliation described in subsection (i) of this section of all eligible state providers. Recouped funds from non-state providers will be redistributed proportionately to eligible non-state providers as follows:

(1) For demonstration years 1-6 (October 1, 2011 – September 30, 2017), HHSC will use the following methodology to redistribute recouped funds:

(A) the non-federal share will be returned to the governmental entity that provided it during the program year;

(B) the federal share will be distributed proportionately among all non-state providers eligible for additional payments that have a source of the non-federal share of the payments; and

(C) the federal share that does not have a source of non-federal share will be returned to CMS.

(2) For demonstration years 7-8 (October 1, 2017 – September 30, 2019), HHSC will use the following methodology to redistribute recouped funds:

(A) To calculate a weight that will be applied to all non-state providers, HHSC will divide the final hospital-specific limit described in §355.8066(c)(2) of this title by the final hospital-specific limit described in §355.8066(c)(2) of this title that has not offset payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer. HHSC will add 1 to the quotient. Any non-state provider who has a resulting weight of less than 1 will receive a weight of 1.

(B) HHSC will make a first pass allocation by multiplying the weight described in subsection (k)(2)(A) of this section by the final remaining UCC calculated in the reconciliation described in subsection (i) of this section. HHSC will divide the product by the total remaining UCCs for all non-state providers. HHSC will multiply the quotient by the total amount of recouped dollars available for redistribution described in subsection (j)(1) of this section.

(C) After the first pass allocation, HHSC will cap non-state providers at their final remaining UCC. A second pass allocation will occur in the event non-state providers were paid over their final remaining UCC after the weight in subsection (k)(2)(A) of this section was applied. HHSC will calculate the second pass by dividing the final remaining UCC calculated in the reconciliation described in subsection (i) of this section by the total remaining UCCs for all non-state providers after accounting for first pass payments. HHSC will multiply the quotient by the total amount of funds in excess of total UCCs for non-state providers capped at their total UCC.

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

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

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

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

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