TO: Hospital Payment Advisory Committee

DATE: November 3, 2022

FROM: Rene Cantu, Director of Hospitals, Provider Finance

SUBJECT: Waiver Payments to Physician Group Practices for Uncompensated Charity Care

Agenda Item No.: 5

Amendments to: Section 355.8212, relating to Waiver Payments to Hospitals for Uncompensated Charity Care and Section 355.8214, relating to Waiver Payments to Physician Group Practices for Uncompensated Charity Care.

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

The Texas Health and Human Services Commission (HHSC) proposes an amendment to Section 355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care, and Section 355.8214, concerning Waiver Payments to Physician Group Practices for Uncompensated Charity Care.

The Uncompensated Care (UC) payments are made by the Health and Human Services Commission (HHSC) to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Attachment H of the 1115 Waiver establishes rules and guidelines for the State to claim federal matching funds for UC payments to hospitals, clinics, and other provider types. The purpose of Texas Physician Uncompensated Care (TXPUC) is to determine the physician professional costs related to services provided to charity care patients by physician organizations that may be reimbursable from the Uncompensated Care pool. This proposal defines certain TXPUC provider classes and updates and clarifies other amendments.

This amendment updates the definition and the methodology used to allocate funds to physician groups. The current rule does not define the different classes of physician groups and allocates funds equally. The amended rule will add "State-owned" and "Non-State-owned" physician group classes and allow the application of different allocation methodologies to each newly defined class. "State-owned" physician groups will now have a different allocation methodology of funds while the "Non-State-owned" physician groups' methodology remains unchanged. Minor grammatical and formatting edits were made to the rule text.

ISSUES AND ALTERNATIVES:

None.

STAKEHOLDER INVOLVEMENT:

Comments on the proposed rule will be reviewed and evaluated during the comment period.

FISCAL IMPACT:

None.

RULE DEVELOPMENT SCHEDULE:

September 2022	Publish proposed rules in *Texas Register*
November 3, 2022	Present to Hospital Payment Advisory Committee
November 17, 2022	Present to HHSC Executive Council
December 2022	Publish adopted rules in *Texas Register*
December 2022	Effective date

REQUESTED ACTION:

☐ The HPAC 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 PROGRAMS

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §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.

BACKGROUND AND PURPOSE

The Uncompensated Care (UC) payments are made by HHSC to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Attachment H of the 1115 Waiver establishes rules and guidelines for the State to claim federal matching funds for UC payments to hospitals, clinics, and other provider types. The purpose of Texas Physician Uncompensated Care (TXPUC) is to determine the physician professional costs related to services provided to charity care patients by physician organizations that may be reimbursable from the Uncompensated Care pool. This proposal defines certain TXPUC provider classes and updates and makes other clarifying amendments.

This amendment updates the definition and the methodology used to allocate funds to physician groups. The current rule does not define the different classes of physician groups and allocates funds equally. The amended rule will add "State-owned" and "Non-State-owned" physician group classes and allow the application of different allocation methodologies to each newly defined class. "State-owned" physician groups will now have a different allocation methodology of funds while the "Non-State-owned" physician groups' methodology remains unchanged. Minor grammatical and formatting edits were made to the rule text.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.8212(d) confirms the requirement that all transfers must meet applicable federal requirements.

The proposed amendment to §355.8212(f)(2) defines the physician group practice pool for demonstration years nine and after. Subparagraph (B)(i) and (ii) is added to subsection (f)(2) to define the physician group practice pool for demonstration years ten and after and to provide the physician group practice allocation for state-owned pool funds at an amount less than or equal to the total annual maximum uncompensated-care payment amount for these physicians. Subparagraph (C) is amended to define the physician group practice allocation for non-state-owned provider pools. Subparagraph (C)(i) is amended to define the applicability of the

physician group practice non-state-owned provider pools to the applicable demonstration year. Subparagraph (C)(i)(II) is amended to clarify the use of physician's charity-care costs used for the current demonstration year and charity-care costs used for the prior demonstration year for dental and ambulance. Subparagraph (C)(ii)(II) is amended to include "non-state-owned physician group."

The proposed amendment to §355.8214(b)(1) defines the allocation amount for state-owned and non-state owned physician groups for demonstration years eleven and forward. New paragraph (9) defines "non-state-owned physician group." New paragraph (12) defines "Service Delivery Area." New paragraph (13) defines "state-owned physician group."

The proposed amendment to §355.8214(d)(1) confirms the requirement that all transfers must meet applicable federal requirements.

The proposed amendment to §355.8214(f)(1) defines funding limitations for demonstration years nine and ten. Paragraph (2) is amended to define funding limitations for demonstration years eleven and forward.

The proposed amendment to §355.8214(g) adds paragraph (5) and (6) to define physician group service delivery area sub-pools. Old paragraph (6) is deleted.

Minor edits are made to §355.8214(h)(2)(B).

Grammatical and formatting edits are made to §355.8212 and §355.8214. Edits include spelling out abbreviated terms, adding lead-in phrases for consistency, and correcting formatting, references, and punctuation.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules 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 HHSC employee positions;

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

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

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

(6) the proposed rules will expand existing rules;

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

(8) the proposed rules 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. The rules do not impose any additional costs on small businesses, micro-businesses, or rural communities required to comply with the rules and do not require any change in current business practices.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because these rules do 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 rules are in effect, the public benefit will be increased transparency in the distribution of UC funding.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because these rules update the percentage allocation of funds in the UC program but do not add additional requirements or costs to comply.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to their 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

A public hearing to receive comments on the proposal will be held by HHSC through a hybrid webinar (in person and online). The meeting date and time will be posted on the HHSC Communications and Events Website at https://hhs.texas.gov/about-hhs/communications-events and the HHSC Provider Finance Hospitals website at

https://pfd.hhs.texas.gov/hospitals-clinic/hospital-services/disproportionate-share-hospitals.

Please contact PFD_Hospitals@hhsc.state.tx.us if you have questions.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to the HHSC Provider Finance for Hospitals department at pfd_hospitals@hhsc.state.tx.us.

Written comments on the proposal may be submitted to the HHSC Provider Finance Department, 4601 Guadalupe Street, Austin, TX 78751 (Mail Code H-400); P.O. Box 149030, Austin, TX 78714-9030 (Mail Code H-400); by fax to (512)-730-7475; or by email to UCTools@hhsc.state.tx.us.

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) faxed or emailed before midnight on the last day of the comment period. If the 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 emailing comments, please indicate "Comments on Proposed Rule 22R110" in the subject line.

STATUTORY AUTHORITY

The amendments are proposed under Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with authority to administer the federal medical assistance (Medicaid) program in Texas; 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 Government Code §531.0055, Chapter 531, and Texas Human Resources Code Chapter 32.

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 contact PFD_Hospitals@hhsc.state.tx.us or (737) 867-7813.

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

§355.8212. 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) Allocation amount--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 or individual hospital, as described in subsections (f)(2) and (g)(6) 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 uninsured patients 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 Principles and Practices Board Statement 15 (December 2012). Charity care includes full or partial discounts given to uninsured patients 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 (DSH) program year. Demonstration year one corresponded to the 2012 DSH program year, October 1, 2011, through September 30, 2012.

(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) 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.

(17) 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.

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

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

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

(B) was designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH) before October 1, 2021; or

(C) is designated by Medicare as a CAH, SCH, or 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

(D) meets all of the following:

(i) has 100 or fewer beds;

(ii) is designated by Medicare as a CAH, SCH, or an[~~a~~] RRC; and

(iii) is located in an MSA.

(20) Service Delivery Area (SDA)--The counties included in any HHSC-defined geographic area as applicable to each Managed Care Organization (MCO) [~~MCO~~].

(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) Eligible Hospitals. 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) Governmental Entity Acknowledgments. 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 Provider Finance 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-) the new affiliation cut-off date posted on HHSC Provider Finance Departments' website for each payment under this section.

(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 Provider Finance Department's website for each payment under this section.

(III) Notification Requirement. 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) Request for Modifications. The certification forms must not be modified except for those changes approved by HHSC prior to submission.

(-a-) Within 10 business days of HHSC Provider Finance 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) Failure to Submit Required Documentation. A hospital that fails to submit the required documentation in compliance with this subparagraph is not eligible to 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, 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 Provider Finance 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. Governmental entities that choose to support payments under this section affirm that funds transferred to HHSC meet federal requirements related to the non-federal share of such payments, including §1903(w) of the Social Security Act. Prior to processing uncompensated-care payments for the final payment period within a waiver demonstration year for any uncompensated-care pool or sub-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 or sub-pool to determine the amount of funding available to support payments from that pool or sub-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 uncompensated-care pools: for demonstration years nine and ten, a state-owned hospital pool, a non-state-owned hospital pool, a physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool. Beginning with demonstration year eleven and after, the physician group practice pool will be further divided into a state-owned physician group practice pool and a non-state-owned physician group practice 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) The state-owned physician group practice pool.

(i) Beginning in demonstration year eleven, the state-owned physician group practice pool funds uncompensated-care payments to state-owned physician groups, as defined in §355.8214 of this division (relating to Waiver Payments to Physician Group Practices for Uncompensated Charity Care).

(ii) HHSC will determine the allocation for this pool at an amount less than or equal to the total maximum uncompensated-care payment amount for these physicians.

(C)[~~(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) and the state-owned physician group practice pool under subparagraph (B) of this paragraph. HHSC will allocate the funds among non-state-owned provider pools based on the following amounts.

(i) For the physician group practice pool in demonstration years nine and ten, or the non-state-owned physician group practice pool beginning in demonstration year eleven, the governmental ambulance provider pool, and the publicly owned dental provider pool:

(I) for demonstration year nine, an amount to equal the percentage of the applicable total uncompensated-care pool amount paid to each group in

demonstration year six; and

(II) for demonstration years ten and after, an amount to equal a percentage determined by HHSC annually based on factors including the amount of reported charity-care costs [~~for the previous demonstration year~~] and the ratio of reported charity-care costs to hospitals' charity-care costs. For physicians, current year charity-care costs will be used, while for dental and ambulance providers, prior year charity-care costs will be used.

(ii) For the non-state-owned hospital pool, all of the remaining funds after the allocations described in clause (i) of this subparagraph. HHSC will further allocate the funds in the non-state-owned hospital pool among all hospitals in the pool and create non-state-owned hospital sub-pools as follows:

(I) calculate a revised maximum payment amount for each non-state-owned hospital as described in subsection (g)(6) of this section and allocate that amount to the hospital; and

(II) group all non-state-owned hospitals and non-state-owned physician groups into sub-pools based on their geographic location within one of the state's Medicaid service delivery areas (SDAs), as described in subsection (g)(7) of this section.

(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 providers in each pool or sub-pool are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(4) If for any reason funds allocated to a provider pool or to individual providers within a sub-pool are not paid to providers in that pool or sub-pool for the demonstration year, the funds will be redistributed to other provider pools based on each pool's pro-rata share of remaining uncompensated costs for the same demonstration year. The redistribution will occur when the reconciliation for that demonstration year is performed.

(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 pre-populated in or reported on the uncompensated-care application, as described in paragraph (3) of this subsection, reduced by interim DSH payments for the same program period, if any, that reimburse the hospital for the same costs. To identify DSH payments that reimburse the hospital for the same costs, HHSC will:

(I) use [~~Use~~] self-reported information on the application to identify charges that can be claimed by the hospital in both DSH and Uncompensated Care (UC) [~~UC~~], convert the charges to cost, and reduce the cost by any applicable payments described in paragraph (3) of this subsection;

(II) calculate [~~Calculate~~] a DSH-only uninsured shortfall by reducing the hospital's total uninsured costs, calculated as described in §355.8066 of this subchapter [~~chapter~~], by the result from subclause (I) of this clause; and

(III) reduce [~~Reduce~~] the interim DSH payment amount by the sum of:

(-a-) the DSH-only uninsured shortfall calculated as described in subclause (II) of this clause; and

(-b-) the hospital's Medicaid shortfall, calculated as described in §355.8066 of this subchapter [~~chapter~~].

(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 to that hospital and private hospitals 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 state payment cap for interim payments or DSH hospital-specific limit (HSL) in the UC reconciliation plus the unreimbursed costs of inpatient and outpatient services provided to uninsured charity-care patients not included in the state payment cap or HSL for the corresponding program year.

(3) Hospital charity-care costs.

(A) For each hospital required by Medicare to submit schedule S-10 of the CMS 2552-10 cost report, HHSC will pre-populate the uncompensated-care application described in paragraph (1) of this subsection with the uninsured charity-care charges and payments reported by the hospital on schedule S-10 for the hospital's cost reporting period ending in the calendar year two years before the demonstration year. For example, for demonstration year 9, which coincides with the federal fiscal year 2020, HHSC will use data from the hospital's cost reporting period ending in the calendar year 2018. Hospitals should also report any additional payments associated with their uninsured charity charges that were not captured in worksheet S-10 in the application described in paragraph (1) of this subsection.

(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 and payments in compliance with the instructions on the uncompensated-care application described in paragraph (1) of this subsection.

(i) The instructions for reporting eligible charity-care costs in the application will be consistent with instructions contained in schedule S-10.

(ii) An IMD may not report charity-care charges for services provided during the data year to patients aged 21 through 64.

(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 uninsured 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, and provide sufficient information for HHSC to verify the link between the changes to the hospital's operations or circumstances and the specified numbers used to calculate the amount of the adjustment.

(i) Such supporting documentation must include:

(I) a detailed description of the specific changes to the hospital's operations or circumstances;

(II) verifiable information from the hospital's general ledger, financial statements, patient accounting records or other relevant sources that support the numbers used to calculate the adjustment; and

(III) if applicable, a copy of any relevant contracts, financial assistance policies, or other policies or procedures [~~policies/procedures~~] that verify the change to the hospital's operations or circumstances.

(ii) 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 state payment cap 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 allocation amounts. 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 allocation amount 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 allocation amount.

(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)[~~(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 allocation amount 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 allocation amount for the pool, each provider in the pool is eligible to receive its maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph without any reduction to remain within the pool allocation amount.

(D) If the cumulative maximum payment amount for the pool from subparagraph (B)(iii) of this paragraph is more than the allocation amount 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) The physician group practice pool, the governmental ambulance provider pool, and the publicly owned dental provider pool. HHSC will calculate a capped payment amount equal to the product of each 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) The non-state-owned hospital pool.

(I) For rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all rural hospitals in the pool;

(-b-) in demonstration year:

(-1-) nine and ten, set aside for rural hospitals the amount calculated in item (-a-) of this subclause; or

(-2-) eleven and after, set aside for rural hospitals the lesser of the amount calculated in item (-a-) of this subclause or the amount set aside for rural hospitals in demonstration year ten;

(-c-) calculate a ratio to equal the rural hospital set-aside amount from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(II) For non-rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all non-rural hospitals in the pool;

(-b-) calculate an amount to equal the difference between the pool allocation amount from subsection (f)(2) of this section and the set-aside amount from subclause (I)(-b-) of this clause;

(-c-) calculate a ratio to equal the result from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for non-rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each non-rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(III) The revised maximum uncompensated-care payment for the payment period equals the lesser of:

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

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

(IV) HHSC will allocate to each non-state-owned hospital the revised maximum uncompensated-care payment amount from subclause (III) of this clause.

(7) Non-state-owned hospital SDA sub-pools. After HHSC completes the calculations described in paragraph (6) of this subsection, HHSC will place each non-state-owned hospital into a sub-pool based on the hospital's geographic location in a designated Medicaid SDA for purposes of the calculations described in subsection (h) of this section.

(8) 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 a duplication of costs.

(9) 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:

(i) in demonstration year nine, be based on uninsured charity-care costs reported by the hospital on schedule S-10 of the CMS 2552-10 cost report used for purposes of sizing the UC pool, or on documentation submitted for that purpose by each hospital not required to submit schedule S-10 with its [~~their~~] cost report; and

(ii) in demonstration years ten and after, 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 the 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 or sub-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 or sub-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 or sub-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 or sub-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 or sub-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 providers [~~hospitals~~] in the pool or sub-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 or sub-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 governmental entities in proportion to each entity's initial contribution to funding the program for that hospital's SDA in the applicable program year.

(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 the hospital has not paid the full amount of the recoupment or entered into a written agreement with HHSC to do so within 30 days of the hospital's receipt of HHSC's written notice of recoupment, 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) Allocation amount--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). Starting in demonstration year eleven, the physician group practice uncompensated-care pool will be further divided into a state-owned physician group practice pool and a non-state-owned physician group practice pool.

(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 uninsured patients 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 Principles and Practices Board Statement 15 (December 2012). Charity care includes full or partial discounts given to uninsured patients 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. Demonstration year one was October 1, 2011, through September 30, 2012.

(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) Non-state-owned physician group--Any physician group not included in the definition of state-owned physician group that qualifies for uncompensated care payments.

(10)[~~(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.

(11)[~~(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.

(12) Service Delivery Area (SDA)--The counties included in any HHSC-defined geographic area as applicable to each Managed Care Organization.

(13) State-owned physician group--An eligible physician group practice that is state-owned or state-operated. Physicians under contract with such a physician group practice are not included. Eligible state-owned or state-operated physician group practices consist of those affiliated with:

(A) University of Texas--Southwestern;

(B) University of Texas--San Antonio;

(C) University of Texas--Tyler;

(D) University of Texas--Houston;

(E) University of Texas Medical Branch--Galveston;

(F) University of Texas--MD Anderson Cancer Center;

(G) University of North Texas;

(H) Texas Tech University--Amarillo;

(I) Texas Tech University--El Paso;

(J) Texas Tech University--Lubbock;

(K) Texas Tech University--Odessa; or

(L) Texas A&M Health Science Center.

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

(15)[~~(12)~~] Uncompensated-care physician application--A form prescribed by

HHSC to identify uncompensated costs for Medicaid-enrolled providers.

(16)[~~(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.

(17)[~~(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. Governmental entities that choose to support payments under this section affirm that funds transferred to HHSC meet federal requirements related to the non-federal share of such payments, including §1903(w) of the Social Security Act. 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 and posted on HHSC's website.

(f) Funding limitations.

(1) For demonstration years nine and ten, payments [~~Payments~~] made under this section are limited by the maximum 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 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. 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.

(2) Beginning in demonstration year eleven, payments made under this section are limited by the maximum amount of funds allocated to the non-state-owned physician group practice uncompensated-care pool for the demonstration year as described in §355.8212 of this division. Non-state-owned physicians as defined in subsection (b) of this section, are reimbursed through the non-state-owned physician group practice uncompensated-care pool. If payments for uncompensated care for the non-state-owned physician group practice uncompensated-care pool attributable to a demonstration year are expected to exceed the amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the non-state-owned pool as described in subsection (g)(4) of this section. 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[~~,~~] and provide sufficient information for HHSC to verify the link between the changes to the provider's operations or circumstances and the specified numbers used to calculate the amount of the adjustment.

(i) Such supporting documentation must include:

(I) a detailed description of the specific changes to the provider's operations or circumstances;

(II) verifiable information from the provider's general ledger, financial statements, patient accounting records or other relevant sources that support the numbers used to calculate the adjustment; and

(III) if applicable, a copy of any relevant contracts, financial assistance policies~~,~~ or other policies or procedures [~~policies/procedures~~] that verify the change to the provider's operations or circumstances.

(ii) 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 allocation amount. 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 allocation amount 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 allocation amount.

(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 allocation amount 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 allocation amount for the pool, each provider is eligible to receive its [~~their~~] maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph without any reduction to remain within the pool allocation amount.

(D) If the cumulative maximum payment amount for the pool from subparagraph (B)(iii) of this paragraph is more than the allocation amount 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 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 allocation amount 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) Physician group or non-state-owned physician group SDA sub-pools. This section pertains to all physician groups prior to demonstration year eleven and non-state-owned physician groups beginning in demonstration year twelve. After HHSC completes the calculations described in paragraph (4) of this subsection, HHSC will add each physician group or non-state-owned physician group to a sub-pool with the non-state-owned hospitals described in §355.8212 of this division based on the physician group's geographic location in a designated Medicaid SDA for purposes of the calculations described in subsection (h) of this section.

(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 a 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 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:

(i) in demonstration year nine, be based on documentation submitted by the physician group practice on a form designated by HHSC for that purpose; and

(ii) in demonstration years ten and after, 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 providers [~~physician group practices~~] in the pool or sub-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.