NUECES COUNTY HOSPITAL DISTRICT
HEALTH CARE PROVIDER PARTICIPATION PROGRAM
REVISED RULES AND PROCEDURES
Effective: August 1, 2023

General Provisions

Rule 1. Definitions. In these rules and procedures:

(a) "Mandatory payment" means a mandatory payment authorized under Texas Health and Safety Code, Chapter 298C.

(b) "Institutional health care provider" means a hospital that is not owned and operated by a federal or state government and provides inpatient hospital services.

(c) "Paying provider" or "Paying hospital" means an institutional health care provider required to make a mandatory payment under Texas Health and Safety Code, Chapter 298C.

(d) "Program" means the health care provider participation program authorized under Texas Health & Safety Code, Chapter 298C.

(e) "Hospital District" means the Nueces County Hospital District.

(f) "Board of Managers" means the Board of Managers of the Nueces County Hospital District.

Rule 2. Health Care Provider Participation Program; Participation in Program.

(a) The Program authorizes the Hospital District to collect a mandatory payment from each institutional health care provider located in the Hospital District to be deposited in a local provider participation fund established by the Hospital District. Money in the fund may be used by the Hospital District to fund certain intergovernmental transfers as provided by these rules and procedures.

(b) The Board of Managers may adopt an order authorizing the Hospital District to participate in the Program, subject to the limitations provided by these rules and procedures.

(c) To the extent any provision or procedure under Texas Health & Safety Code, Chapter 298C causes a mandatory payment to be ineligible for federal matching funds, the Hospital District may provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare & Medicaid Services.

Powers and Duties of Board of Managers

Rule 3. Limitation on Authority to Require Mandatory Payment. The Hospital District may require a mandatory payment from an institutional health care provider only in the manner provided in these rules and procedures.

Rule 4. Majority Vote Required Prior to Mandatory Payment. The Hospital District may not collect a mandatory payment without an affirmative vote of a majority of the

members of the Board of Managers authorizing the Hospital District to participate in the Program.

Rule 5. Institutional Health Care Provider Reporting; Inspection of Records.

(a) The Hospital District shall require each institutional health care provider to submit to the Hospital District a copy of any financial and utilization data required by and reported to the Department of State Health Services under Texas Health & Safety Code, §311.032 and §311.033 and any rules adopted by the Executive Commissioner of the Texas Health and Human Services Commission to implement those sections.

(b) The Hospital District may inspect the records of an institutional health care provider to the extent necessary to ensure that the institutional health care provider has submitted all required data under this Rule.

General Financing Provisions

Rule 6. Hearing.

(a) Each year, the Board of Managers shall hold a public hearing on the amounts of any mandatory payments that the Board intends to require during the year and how the revenue derived from those payments is to be spent.

(b) Not later than the fifth (5^{th}) day before the date of the hearing required under Subdivision 6(a), the Board of Managers shall publish notice of the hearing in a newspaper of general circulation in the Hospital District.

(c) A representative of a paying hospital is entitled to appear at the time and place designated in the public notice and to be heard regarding any matter related to the mandatory payments.

Rule 7. Depository and Investment of Funds.

(a) The Hospital District shall designate one or more banks as the depository for the Hospital District local provider participation fund.

(b) All income received by the Hospital District under these rules and procedures, including the revenue from mandatory payments remaining after fees for assessing and collecting the payments are deducted, shall be deposited with the Hospital District depository in the District's local provider participation fund and may be withdrawn only as provided by these rules and procedures.

(c) All funds under these rules and procedures shall be secured in the manner provided for securing other Hospital District funds.

(d) All funds received under these rules and procedures may be invested consistent with the Investment Policy of the Hospital District, except that such investment shall be limited to overnight funds.

Rule 8. Local Provider Participation Fund; Authorized Uses of Money.

(a) If the Hospital District requires a mandatory payment, it shall create a local provider participation fund.

(b) The local provider participation fund of the Hospital District consists of:

(1) all revenue received by the Hospital District attributable to mandatory payments;

(2) money received from the Texas Health and Human Services Commission as a refund of an intergovernmental transfer under the Program, provided that the intergovernmental transfer does not receive a federal matching payment; and

(3) the earnings of the fund.

(c) Money deposited to the local provider participation fund may be used only to:

(1) fund intergovernmental transfers from the Hospital District to the State of Texas to provide the nonfederal share of Medicaid payments for:

(A) uncompensated care payments to hospitals in the Medicaid managed care service area in which the Hospital District is located, if those payments are authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315);

(B) delivery system reform incentive payments, if those payments are authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315);

(C) uniform rate enhancements for hospitals in the Medicaid managed care service area in which the Hospital District is located;

(D) payments available under another waiver program authorizing payments that are substantially similar to Medicaid payments to hospitals described by Paragraph (A), (B), or (C); or

(E) any reimbursement to hospitals for which federal matching funds are available;

(2) pay the administrative expenses of the Hospital District in administering the Program, including the collateralization of deposits;

(3) refund of a mandatory payment collected in error from a paying hospital;

(4) refund to paying providers the proportionate share of money that the Hospital District:

(A) receives from the Texas Health and Human Services Commission that is not used to fund the nonfederal share of Medicaid supplemental payment program payments or uniform rate enhancements described by Subdivision (1)(C); or

(B) determines cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments of uniform rate enhancements described by Subdivision (1)(C).

(5) transfer funds to the Texas Health and Human Services Commission if the Hospital District is legally required to transfer the funds to address a disallowance of federal matching funds with respect to programs for which the Hospital District made intergovernmental transfers described by Subdivision (c)(1); and

(6) reimburse the Hospital District if the Hospital District is required by the rules governing the uniform rate enhancement program described by Subdivision (1)(C) to incur an expense or forego Medicaid reimbursements from the State because the balance of the local provider participation fund is not sufficient to fund that rate enhancement program.

(d) Money in the local provider participation fund may not be commingled with other Hospital District funds.

(e) An intergovernmental transfer of funds described by Subdivision (c)(1) and any funds received by the Hospital District as a result of an intergovernmental transfer described by that rule may not be used by the State, Hospital District, or other entity to expand Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152).

Mandatory Payments

Rule 9. Mandatory Payments Based on Paying Hospital Net Patient Revenue.

(a) Except as provided by Rule 11, if the Board of Managers collects a mandatory payment, it may require that a mandatory payment be assessed annually or periodically throughout the fiscal year at the discretion of the Board of Managers on the net patient revenue of each institutional health care provider located in the boundaries of the Hospital District.

(b) The Board of Managers shall provide an institutional health care provider written notice of each assessment and the mandatory payments shall be made 30 days following the date of receipt of the notice of payment.

(c) In the first year in which the mandatory payment is required, the mandatory payment is assessed based on the most recent fiscal year data collected pursuant to Subdivision 5(a). If no such data are available for an institutional health care provider, the mandatory payment may be calculated based on the institutional health care provider's Medicare cost report submitted for the previous fiscal year or for the closest subsequent fiscal year for which the provider submitted the Medicare cost report.

(d) The net patient revenue basis of the mandatory payment may be updated during the fiscal year using the most recent fiscal year data collected pursuant to Subdivision 5(a). Use of data that is updated during the fiscal year does not require Board of Managers approval.

Rule 10. Mandatory Payment Requirements

(a) The amount of a mandatory payment must be uniformly proportionate with the amount of net patient revenue generated by each paying hospital in the Hospital District.

(b) If the Board of Managers requires a mandatory payment, it shall set the amount of the mandatory payment; the aggregate amount of the mandatory payments required of all paying providers in the Hospital District may not exceed six percent (6%)

of the aggregate net patient revenue from hospital services provided by all paying providers within boundaries of the District.

(c) Subject to the maximum amount prescribed by Rule 11(a), if the Board of Managers requires a mandatory payment, it shall set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the Hospital District for activities under these rules and procedures and to fund purposes described in Rule 8(c).

(i) The annual amount of revenue from mandatory payments used for administrative expenses of the Hospital District for activities under these rules and procedures is $150,000, plus the cost of collateralization of deposits, regardless of actual expenses.

(d) The mandatory payment may not be collected for the purpose of raising general revenue or any amount in excess of the amount reasonably necessary to fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements for hospitals to cover the administrative expenses of the Hospital District associated with the Program.

(e) To the extent any Program provision or procedure causes a mandatory payment to be ineligible for federal matching funds, the Board may provide by rule for an alternative provision or procedure that conforms to the requirements of federal Centers for Medicare & Medicaid Services.

Rule 11. Mandatory Payment Prohibitions.

(a) The amount of the mandatory payment required of each paying hospital may not exceed an amount that, when added to the amount of the mandatory payments required from all other paying hospitals located in the boundaries of the Hospital District, equals an amount of revenue that exceeds six percent (6%) of the aggregate net patient revenue of all paying hospitals in the Hospital District.

(b) A mandatory payment may not hold harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w).

(c) A paying provider may not add a mandatory payment required under this section as a surcharge to a patient.

(d) A mandatory payment assessed hereunder is not a tax for hospital purposes for purposes of Texas Constitution, Section 4, Article IX or Texas Health and Safety Code, §281.045.

(e) The amount of the mandatory payment required of each paying hospital may not be discounted.

Rule 12. Assessment and Collection of Mandatory Payments.

(a) The Hospital District may designate an official of the Hospital District or contract with another person to assess and collect the mandatory payments.

(b) The person charged by the Hospital District with the assessment and collection of mandatory payments shall charge and deduct from the mandatory payments collected for the Hospital District a collection fee in the amount not to exceed the person's usual and customary charges for like services.

(c) If the person charged with the assessment and collection of mandatory payments is an official of the Hospital District, any revenue from a collection fee charged under Subdivision (b) shall be deposited in the Hospital District's general fund and, if appropriate, shall be reported as fees of the Hospital District.

EXHIBIT A-1

Institutional Health Care Providers

1. CHRISTUS Spohn Hospital Corpus Christi
2. Corpus Christi Rehabilitation Hospital
3. Driscoll Children's Hospital
4. PAM Rehabilitation Hospital of Corpus Christi
5. PAM Specialty Hospital of Corpus Christi North
6. South Texas Surgical Hospital (CHRISTUS Surgical Hospital)
7. The Corpus Christi Medical Center – Bay Area