NUECES COUNTY HOSPITAL DISTRICT
Board of Managers - Regular Meeting
Tuesday, December 17, 2019 at 12:00 PM

Agenda

1. **CALL TO ORDER**

2. **ESTABLISHMENT OF QUORUM**

3. **PUBLIC COMMENT** - Persons wishing to comment on any item(s) on the agenda or any subject within the Board's responsibilities must sign-in on the "Agenda Item Request to Speak" form provided at the entrance of the Board meeting room at least five (5) minutes prior to commencement of the meeting. Commenters shall limit their comments to three (3) minutes, except that Commenters addressing the Board through a translator shall limit their comments to six (6) minutes. See the "Public Comment" section of the preceding General Information page for additional information.

4. **CONSENT AGENDA** - See the "Consent Agenda" section of the preceding General Information page for an explanation of the Consent Agenda and for additional information.
   A. Confirm posting of meeting's public notice.

   B. Approve minutes of Board of Managers November 18, 2019 Regular Meeting.

   C. Receive listing of new vendors as of December 12, 2019; listing provided pursuant to Board of Managers Bylaws, Article 2, §2.1 B and Texas Local Government Code, Chapter 176.

   D. Receive revenue reports relating to CHRISTUS Spohn Health System Corporation Membership Agreement for fiscal year-to-date. *(Finance Committee)*

   E. Receive summary payment information on Nueces County health care disbursements for Fiscal Year 2020 year-to-date:
      1) Salaries, benefits, supplies, and intergovernmental transfers at/for Corpus Christi/Nueces County Public Health Department;
      2) Emergency medical services provided in unincorporated areas of Nueces County;
      3) Supplemental and jail diversion program funding for Nueces Center for Mental Health and Intellectual Disabilities;
      4) Medical services provided at County correctional facilities:
         a) Nueces County Jail; and
         b) Nueces County Juvenile Detention Center;
      5) Funding for alcohol and drug abuse treatment programs:
         a) Cenikor (Charlie's Place);
         b) Council on Alcohol and Drug Abuse; and
         c) Palmer Drug Abuse Program;

6) Funding for diabetes prevention and supporting programs. *(Finance Committee)*

F. Receive reports relating to Nueces Aid Program enrollment for the month ended November 30, 2019. *(Finance Committee)*

G. Receive summary information on medical and hospital care provided to the Nueces Aid population consistent with the CHRISTUS Spohn Health System Corporation Membership Agreement for fiscal year-to-date ended November 30, 2019. *(Finance Committee)*

H. Ratify Administrator's action(s) performed as part of his duties directing the affairs of the Hospital District as required by the Board of Managers or by law; duties established pursuant to Texas Health and Safety Code, §281.026(e):

1) Execution of bank depository-related Agreements between the Hospital District and Frost Bank for term December 1, 2019 - September 30, 2023:
   a) Bank Depository Agreement;
   b) Security Agreement; and
   c) Third Party Custodian Agreement (between Hospital District, Frost Bank, and Bank of New York Mellon Trust Company). *(Finance Committee)*
2) Execution of Amendment No. 3 to Health Services Agreement Nueces County Correctional Facilities between Nueces County, Hospital District, and Wellpath LLC (formerly Correct Care Solutions, LLC); Amendment exercised final one (1)-year renewal option that extended the Agreement's termination date to November 30, 2020 and increased annual compensation to $3,504,484.00. *(Finance Committee)*
3) Payment of interest amount of $18,025.61 on refund in Case No. 18-0660, In Re Occidental Chemical Corporation, Oxy Ingelside Energy Center LLC, et al., In the Texas Supreme Court. *(Finance Committee)*

5. **REGULAR AGENDA:**

A. **Community Mental Health Initiatives:**

1) Receive report from Nueces Center for Mental Health and Intellectual Disabilities (NCMHID) on activities performed under Interlocal Agreement between Nueces County, NCMHID, and Hospital District relating to diversion of persons from jails or other detention facilities, provision of crisis intervention teams, expansion of mobile crisis outreach, and development of jail-based competency restoration. ***(INFORMATION)***

2) Receive report(s) on work performed under Professional Services Agreement between Nueces County, Meadows Mental Health Policy Institute, and Hospital District relating to preparation of a comprehensive needs assessment for Nueces County that can serve as the basis for a systematic approach to providing services for mental illnesses and substance abuse disorders in the County. ***(INFORMATION)***

3) Receive report(s) on work performed under Professional Services Agreement between Nueces County, BeHealthle, and Hospital District relating to the Nueces County Community Collaborative Program/Jail Diversion Program. ***(INFORMATION)***

B. **Indigent Health Care:**

1) Receive and discuss information from CHRISTUS Spohn Health System Corporation relating to:
   a) Medical aid and hospital care provided to the Nueces Aid Program population consistent with the CHRISTUS Spohn Health System Corporation Membership Agreement and related matters; and
   b) Programs, projects, and/or activities at CHRISTUS Spohn Hospital Corpus Christi-Memorial and other Hospital District-owned facilities and related matters. ***(INFORMATION)***

2) Receive and discuss update from CHRISTUS Spohn Health System Corporation relating to operation, construction, transition, planning, and/or demolition activities pursuant to Sections 3.5 and 3.9 of Amended and Restated Schedule 1 to Spohn Membership Agreement, as schedule to CHRISTUS Spohn Health System Corporation Amended and Restated Membership Agreement:
   a) Operations of Dr. Hector P. Garcia - Memorial Family Health Center located on Hospital District-owned property at 2606 Hospital Boulevard, Corpus Christi, Texas;
   b) Construction and/or demolition activities at CHRISTUS Spohn Hospital Corpus Christi-Shoreline located at 600 Elizabeth Street, Corpus Christi, Texas;
   c) Transition of mental health services from Hospital District-owned hospital presently known as CHRISTUS Spohn Hospital Corpus Christi-Memorial (formerly known as Memorial Medical Center) located at 2606 Hospital Boulevard to CHRISTUS Spohn Hospital Corpus Christi-Shoreline located at 600 Elizabeth Street, both facility locations in Corpus Christi, Texas; and
   d) Planning orderly transition of mental health services from Hospital District-owned hospital presently known as CHRISTUS Spohn Hospital Corpus Christi-Memorial (formerly known as Memorial Medical Center) located at 2606 Hospital Boulevard to CHRISTUS Spohn Hospital Corpus Christi-Shoreline located at 600 Elizabeth Street, both facility locations in Corpus Christi, Texas. ***(INFORMATION)***

3) Receive update on referral of potentially qualified Nueces Aid Program enrollees to CHRISTUS Spohn Health System for evaluation toward voluntary enrollment in a health insurance exchange plan offered by CHRISTUS Health Plan. ***(INFORMATION)***

4) Consider request from CHRISTUS Spohn Health System Corporation to amend Nueces Aid Program Handbook Covered Services Policy NA004, Section IV.G.5 and 6 relating to Outpatient Prescription Drug Services to increase the current prescription maximum for common chronic diseases for new and refilled

prescriptions from 34 to 90 days for each medication; and authorize Administrator to issue amended Handbook Policy to be effective January 1, 2020. ***(ACTION)***

C. **Finance Committee:**

1) Receive introductory/planning briefing from Collier, Johnson, & Woods, P.C. Certified Public Accountants relating to their audit of the Hospital District's financial statements for fiscal year ended September 30, 2019. ***(INFORMATION)***

2) Receive and approve unaudited Hospital District financial statements for fiscal year ended September 30, 2019 and month and fiscal year-to-date period ended October 31, 2019. ***(ACTION)***

3) Receive summary report to date of intergovernmental transfers made by Hospital District in support of local and other healthcare providers participating in Medicaid supplemental payment programs sponsored by the Texas Health and Human Commission year-to-date:
   a) Texas Healthcare Transformation and Quality Improvement Program (Medicaid 1115 Waiver):
      (1) Delivery System Reform Incentive Payment (DSRIP) pool; and
      (2) Hospital Uncompensated Care (UC) pool.
   b) Disproportionate Share Hospitals (DSH) program;
   c) Network Access Improvement Program (NAIP);
   d) Uniform Hospital Rate Increase Program (UHRIP); and
   e) Graduate Medical Education (GME). ***(INFORMATION)***

4) Receive monthly statement of escrow amounts deposited and/or withdrawn by CHRISTUS Spohn Health System Corporation; deposits pursuant to and consistent with Section 3.9.7 of Amended and Restated Schedule 1 to Spohn Membership Agreement, a schedule to CHRISTUS Spohn Health System Corporation Amended and Restated Membership Agreement; receive statements for month ended November 30, 2019. ***(INFORMATION)***

5) Consider escrow disbursement request from CHRISTUS Spohn Health System Corporation relating to: [1] achievement of third milestone relating to construction or renovation of at least thirty-nine (39) emergency department beds at CHRISTUS Spohn Shoreline Hospital; and [2] correction of prior April 2018 escrow disbursement for achievement of second milestone relating to Level II Trauma designation at CHRISTUS Spohn Shoreline Hospital; milestone achievements and escrow amount disbursements pursuant to Amended and Restated Schedule 1, Section 3.9.7(c) and (d) of Amended and Restated Membership Agreement between Nueces County Hospital District and CHRISTUS Spohn Health System Corporation, as amended; and authorize Administrator to execute related documents. ***(ACTION)***

6) Receive information on federal regulations proposed by the Department of Health and Human Services, Centers for Medicare & Medicaid Services relating to the financing of supplemental and base Medicaid payments through the non-federal share, including states' uses of health care-related taxes and bona fide provider-related donations, as well as the requirements on the non-federal share of any Medicaid payment; proposed regulations posted November 18, 2019, *Federal Register*, Vol. 84, No. 222, pp. 63722-63785; and authorize the Administrator to submit related comments. ***(INFORMATION & ACTION)***

D. **Other Business:**

1) Reappoint Mr. Govind Nadkarni as Director to CHRISTUS Spohn Health System Corporation's Board of Directors for three-year term commencing January 1, 2020 and ending December 31, 2022; receive and consider Nueces County Commissioners Court's nomination of the aforesaid individual; concur with Court's nomination and appoint nominee for aforesaid term; Hospital District's appointment pursuant to CHRISTUS Spohn Health System Corporation Amended and Restated Membership Agreement, Article III, Section 3.01(b); and authorize Administrator to notify Commissioners Court and CHRISTUS Spohn Health System Corporation. ***(ACTION)***

2) Amend Hospital District Policy and Procedure No. 302.2 to: [1] add Martin Luther King, Jr. Day as an additional recognized holiday; [2] recognize the last four hours of Thanksgiving Eve as part of Thanksgiving Day holiday; and [3] recognize the last four hours of Christmas Eve as part of Christmas Day holiday; and authorize Administrator to issue amended Policy and Procedure No. 302.2 and to additionally issue amended Policy and Procedure No. 302.4 relating to Paid Time Off to adjust accruals, both to be effective January 1, 2020. ***(ACTION)***

3) Discuss and consider establishing a Hospital District membership in the association Texas Healthcare Trustees, a statewide association affiliated with the Texas Hospital Association that provides education, resources, and leadership development opportunities for healthcare trustees. ***(ACTION)***

4) Adopt Board of Managers Order approving a contingency Professional Services Agreement between Nueces County Appraisal District, Corpus Christi Independent School District, City of Corpus Christi, County of Nueces, and Nueces County Hospital District and the Phipps Deacon Purnell PLLC law firm relating to property tax litigation against Valero Refining-Texas, LP relating to tax years 2018, 2019, and 2020. ***(ACTION)***

5) Decline request from Gulf Cooper & Manufacturing Inc. (GCMI) for Hospital District letter to the Port of Corpus Christi supporting GCMI's proposed establishment and operation of a Foreign Trade Zone on Harbor Island. ***(ACTION)***

E. **Board of Managers Business:**

1) Identify and confirm membership of Board's Standing and Ad-Hoc Committees:

a) Standing Committees:

(1) Finance: Pamela L. Brower, Chair; Vishnu V. Reddy, M.D.; and Daniel W. Dain.

(2) Planning: Vishnu V. Reddy, M.D., Chair; and

(3) Quality Management: John E. Valls, Chair;

b) Ad-Hoc Committees:

(1) Bylaws Review: Daniel W. Dain, Chair; and

(2) Legislative: Belinda Flores, Chair. ***(ACTION)***

2) Discuss and identify items of Board member contact and other information for public posting on the Hospital District's website. ***(ACTION)***

6. **ADMINISTRATOR'S BRIEFING:**

A. Future Board of Managers and Board Committee meetings:

1) Next Scheduled Regular Board Meeting: January 21, 2020, 12 Noon (date, time, and location subject to change); and

2) Next Scheduled Regular Finance Committee Meeting: January 21, 2020, 11:15 AM (date, time, and location subject to change).

7. **CLOSED MEETING** - Public notice is hereby given that the Board of Managers may elect to go into closed meeting session(s) at any time during the meeting to discuss any matter(s) listed on the agenda, when so authorized by the provisions of the Open Meetings Act, Texas Government Code, Chapter 551; the Texas Health and Safety Code, Chapter 161, §161.031, §161.0315, and §161.032; and the Texas Occupations Code, Chapters 151 and 160; and that the Board specifically expects to go into a closed session(s) on the matters listed below. In the event the Board elects to go into closed session(s) regarding an agenda item(s), the section(s) of the Open Meetings Act authorizing the closed session will be publicly announced by the presiding officer. Should any final action, final decision, or final vote be required in the opinion of the Board with regard to any matter considered in closed session(s), then the final action, final decision, final vote shall be either: (a) in the open meeting covered by the Notice upon reconvening of the public meeting; or (b) at a subsequent public meeting of the Board upon notice thereof, as the Board shall determine pursuant to applicable laws.

A. Consultation with legal counsel on the status of the payment of interest on the refund in Case No. 18-0660, In Re Occidental Chemical Corporation, Oxy Ingelside Energy Center LLC, et al., In the Texas Supreme Court; and related matters.

B. Consultation with legal counsel on matters relating to federal regulations proposed by the Department of Health and Human Services, Centers for Medicare & Medicaid Services relating to the financing of supplemental and base Medicaid payments through the non-federal share, including states' uses of health care-related taxes and bona fide provider-related donations, as well as the requirements on the non-federal share of any Medicaid payment; proposed regulations posted November 18, 2019, *Federal Register*, Vol. 84, No. 222, pp. 63722-63785.

8. **OPEN MEETING**

A. Consider final action, decision, or vote on matters discussed or considered in Closed Meeting. ***(ACTION AS NEEDED)***

9. **ADJOURN**

* * *

Kara Sands

Nueces County Clerk
901 Leopard St #201
Corpus Christi, TX 78401

Main: (361)888-0580

Receipt: 20191213000011
Date: 12/13/2019
Time: 08:33AM
By: Margarita S
Station: CLERK04
Status: ORIGINAL COPY

Seq	Item	Document Description	Number	Number Of	Amount	Serial Number
1	Public Notice	PBN	2019880695	8	$3.00	
2	Public Notice	PBN	2019880696	10	$3.00	

Order Total (2) $6.00

Seq	Payment Method	Transaction Id	Comment	Total
1	Cash		361 808 3300	$10.00

Total Payments (1) $10.00

Change Due $-4.00

NUECES COUNTY HOSPITAL DISTRICT

For more information about the County Clerk's office and to search property records online, please visit http://www.nuecesco.com/county-services/county-clerk

VG-12-2019-2019880696

Nueces County
Kara Sands
Nueces County Clerk

Instrument Number: 2019880696

Public Notice

PUBLIC NOTICES

Recorded On: December 13, 2019 08:34 AM

Number of Pages: 10

" Examined and Charged as Follows: "

Total Recording: $3.00

STATE OF TEXAS
Nueces County
I hereby certify that this Instrument was filed in the File Number sequence on the date/time printed hereon, and was duly recorded in the Official Records of Nueces County, Texas

Kara Sands
Nueces County Clerk
Nueces County, TX

Kara Sands

********** **THIS PAGE IS PART OF THE INSTRUMENT** **********
Any provision herein which restricts the Sale, Rental or use of the described REAL PROPERTY because of color or race is invalid and unenforceable under federal law.

File Information:

Document Number:	2019880696
Receipt Number:	20191213000011
Recorded Date/Time:	December 13, 2019 08:34 AM
User:	Margarita S
Station:	CLERK04

Record and Return To:

NUECES COUNTY HOSPITAL DISTRICT

NOTICE OF PUBLIC MEETING

NUECES COUNTY HOSPITAL DISTRICT

Board of Managers - Regular Meeting
Tuesday, December 17, 2019 at 12:00 PM

The Board of Managers of the Nueces County Hospital District ("NCHD") will hold a regular meeting on the date and at the time shown above in the NCHD Board Room located at 555 North Carancahua Street, Room 950-A, Corpus Christi, Texas. Entry is through the main entrance of the Tower II Office Building; the main entrance fronts the intersection of North Carancahua and Mestina Streets. The agenda items for this Board meeting are set forth on the accompanying pages; agenda items are not necessarily considered in the order listed. Meeting materials are available on the NCHD website at www.nchdcc.org/meeting.cfm, click the BoardBook link.

JOHN B. MARTINEZ, J.D.
Chairman

SYLVIA TRYON OLIVER
Vice Chairman

BELINDA FLORES, R.N.
Chairman, Ad-Hoc Legislative Committee

VISHNU V. REDDY, M.D.
Chairman, Planning Committee
Member, Finance Committee

PAMELA L. BROWER, C.P.A.
Chairman, Finance Committee

DANIEL W. DAIN
Chairman, Ad-Hoc Bylaws Review Committee
Member, Finance Committee

JOHN E. VALLS
Chairman, Quality Management Committee

NUECES COUNTY HOSPITAL DISTRICT
555 North Carancahua Street, Suite 950
Corpus Christi, Texas 78401-0835
Telephone: (361) 808-3300
Facsimile: (361) 808-3274
Website: www.nchdcc.org

GENERAL INFORMATION ABOUT THE BOARD OF MANAGERS MEETING AND AGENDA

PUBLIC COMMENT: Members of the public who desire to comment on any agenda item(s), or any subject within the Board's responsibilities, except a matter related to pending litigation, will have an opportunity to address the Board during the public comment section of the meeting agenda. Each commenter must sign in on the "Agenda Item Request to Speak" form provided at the entrance of the Board meeting room and so indicate in writing at least five (5) minutes prior to commencement of the Board meeting. The Board's Bylaws provide that commenters should limit their comments to three (3) minutes and must be appropriate to the agenda item(s) or subjects within the Board's responsibilities. Those persons addressing the Board through a translator are given twice the amount of time, or six (6) minutes to provide their comments. The Bylaws also provide that the presiding officer reserves the right to limit the number and/or duration of public comments. Under the law, the Board may only take action on items specifically listed on the agenda. Subject matter presented during public comment which is not part of the agenda may be referred by the presiding officer to the Hospital District's Administrator for review and subsequent action. Materials submitted during public comment will not be returned unless prior arrangements have been made through the Administrator. At least twelve (12) copies of any document to be used by any public commenter should be available for distribution. The commenter's name and, if applicable, Board agenda item number should be clearly marked on the front of such documents.

To the extent allowed by law, there is no prohibition against public criticism of the Board, including criticism of any act, omission, policy, procedure, program, or service.

CONSENT AGENDA: At most regular meetings, the Board utilizes a Consent Agenda. The Consent Agenda consists of those agenda items which are routine, non-controversial, administrative in nature, not in need of separate attention, and which a member of the Board has not requested be discussed separately. If requested to be discussed separately, that agenda item will be removed from the Consent Agenda by the presiding officer to the Regular Agenda and discussed as a part of the Regular Agenda at the appropriate time. All remaining items listed under the Consent Agenda will be voted upon in a single vote.

REGULAR AGENDA: At most regular meetings, the Board also utilizes a Regular Agenda. The Regular Agenda consists of those agenda items which are non-routine, potentially controversial, not administrative in nature, or otherwise in need of separate attention. Each Regular Agenda item will be voted upon separately if action is required.

CLOSED MEETING: The Board of Managers may elect to go into closed meeting session(s) at any time during the meeting covered by this Notice of Public Meeting to discuss any matter(s) listed on the agenda, when so authorized by the provisions of the Open Meetings Act, Texas Government Code, Chapter 551, §551.001 et seq.; the Texas Health and Safety Code, Chapter 161, §161.031, §161.0315, and §161.032; and the Texas Occupations Code, Chapters 151 and 160; and that the Board specifically expects to go into a closed session(s) on the matters listed in this Notice. In the event the Board elects to go into closed session(s) regarding an agenda item(s) covered by this Notice, the section(s) of the Open Meetings Act authorizing the closed session will be publicly announced by the presiding officer. Should any final action, final decision, or final vote be required in the opinion of the Board with regard to any matter considered in closed session(s), then the final action, final decision, final vote shall be either: (a) in the open meeting covered by the Notice upon reconvening of the public meeting; or (b) at a subsequent public meeting of the Board upon notice thereof, as the Board shall determine pursuant to applicable laws.

AGENDA ITEMS: At the meeting covered by this Notice of Public Meeting, the agenda items shown on the following pages may be discussed, considered, and acted upon. Agenda items are not necessarily considered in the order listed.

AUXILIARY AIDS: Persons needing auxiliary aids such as overhead projectors or other similar devices should contact the Hospital District Administrator's Executive Assistant at (361) 808-3300 at least forty-eight (48) hours in advance of the meeting so that appropriate arrangements may be made.

SPECIAL ACCOMMODATIONS: Persons who plan to attend this Board meeting and who may need special accommodation pursuant to the Americans With Disabilities Act (ADA) should contact the Hospital District Administrator's Executive Assistant at (361) 808-3300 at least forty-eight (48) hours in advance of the meeting so that appropriate arrangements can be made.

DRIVING DIRECTIONS: Driving directions to the building location where the Board meeting will be held are available for viewing or downloading at the Hospital District's website, click the "Contact Us" link and scroll to the bottom of the page for a map and instructions.

TEXAS PUBLIC INFORMATION ACT: Texas law gives you the right to access government records and government officials may not ask why you want them. All government information is presumed to be available to the public. However, certain exceptions may apply to the disclosure of the information. Governmental bodies shall promptly release requested information that is not confidential by law or information for which an exception to the disclosure has been sought. For additional information regarding the rights of requestors, responsibilities of governmental bodies, and the procedures to obtain information, including information to be released, cost of records and information that may be withheld due to an exception under the *Texas Public Information Act,* please review the Texas Attorney General's open government publications webpage.

DRAFT

MINUTES
BOARD OF MANAGERS – REGULAR MEETING
NUECES COUNTY HOSPITAL DISTRICT

November 18, 2019

The of Nueces County Hospital District Board of Managers met at 12:00 p.m., Wednesday, October 16, 2019 in the NCHD Board Room at 555 N. Carancahua, Suite 950-A, Corpus Christi, Texas.

HOSPITAL DISTRICT REPRESENTATIVES:
Jonny F. Hipp, Administrator/CEO
Belinda E. Chism, Assistant Administrator, Administrative Services
Donna Littlefield, Director, Accounting & Finance
Wm. DeWitt Alsup, Attorney, Alsup Law Firm
Melissa Vela, Assistant County Attorney
Melissa Quintanilla, Executive Assistant/Human Resources
Carmina Hernandez Moreno, Administrative Assistant

OTHERS PRESENT:

Yasmene McDaniel	Corpus Christi Medical Center
John Michael	Hanson
Maggie Turner	Nueces County
Karla Ramirez	Behealthle
Sheene Edwards	Behealthle

1. **CALL TO ORDER** – Mr. Martinez, Chairman Pro Tempore
   The Meeting was called to order by Mr. Martinez at 12:03 p.m.

2. **ESTABLISHMENT OF QUORUM** – Mr. Martinez
   A quorum was present with all members in attendance.

   John Martinez – PRESENT
   Sylvia Tryon Oliver – PRESENT

John Valls – PRESENT
Belinda Flores – PRESENT
Vishnu V. Reddy, M.D. – PRESENT
Pamela L. Brower – PRESENT
Daniel W. Dain – PRESENT

3. **WELCOME** - Board welcomes newly-appointed Board members: John E. Valls, Pamela L. Brower, and Daniel W. Dain.

4. **PUBLIC COMMENT** – Requested Copy of "Request to Speak Sign – In Sheet" attached hereto and made part of these minutes for information.

No one to speak for public comment.

5. **CONSENT AGENDA** - See the "Consent Agenda" section of the preceding General Information page for an explanation of the Consent Agenda and for additional information.

A. Confirm posting of meeting's public notice.

B. Approve minutes of Board of Managers October 16, 2019 Regular Meeting.

C. Receive full listing of vendors as of November 14, 2019; listing pursuant to Board of Managers Bylaws, Article 2, §2.1 B and Texas Local Government Code, Chapter 176.

Approval of Censent Agenda Items (5) A-C.
On motion by Mr. Valls and seconded by Ms. Flores.
MOTION CARRIED.

Copy of complete list of vendors as of November 14, 2019 is attached hereto for information and made part of these minutes.

D. Receive hospital providers' quarterly reports relating to certain Indigent Care Affiliation Agreements associated with participation in the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver for the calendar quarter ended September 30, 2019:

1) CHRISTUS Spohn Health System Corporation Hospitals: Alice, Beeville, and Kleberg (Consolidated Report);
2) Corpus Christi Medical Center;
3) DeTar Healthcare System; and

4) Driscoll Children's Hospital.

Copies of Quarterly reports are attached hereto and made part of these minutes.

On motion by Mr. Valls and seconded by Ms. Flores.
MOTION CARRIED.

E. Receive summary payment information on Nueces County health care expenditures for Fiscal Year 2019 and Fiscal Year 2020 year-to-date:

1) Salaries, benefits, supplies, and intergovernmental transfers at/for Corpus Christi/Nueces County Public Health Department;
2) Emergency medical services provided in unincorporated areas of Nueces County;
3) Supplemental and jail diversion program funding for Nueces Center for Mental Health and Intellectual Disabilities;
4) Medical services provided at County correctional facilities:
   a) Nueces County Jail; and
   b) Nueces County Juvenile Detention Center;
5) Funding for alcohol and drug abuse treatment programs:
   a) Cenikor (Charlie's Place);
   b) Council on Alcohol and Drug Abuse; and
   c) Palmer Drug Abuse Program;
6) Funding for diabetes prevention and supporting programs.

Ms. Littlefield explained to the Board of Managers the expenditures. Copies of expenditures are attached hereto and made part of these minutes.
On motion by Mr. Valls, seconded by Dr. Reddy.
MOTION CARRIED.

F. Ratify Administrator's action(s) performed as part of his duties directing the affairs of the Hospital District as required by the Board of Managers or by law; duties established pursuant to Texas Health and Safety Code, §281.026(e):

1) Letter Agreement extending current Frost Bank depository agreement through November 30, 2019;
2) Engagement of Collier, Johnson, & Woods, P.C. Certified Public Accountants to perform an audit of the Hospital District's financial statements of the

governmental activities, each major fund, and aggregate remaining funds for Fiscal year ended September 30, 2019.

3) Contract with Abel's Paving and Construction, Inc. for platting-related site improvements on Hospital District-owned property presently known as CHRISTUS Spohn Hospital Corpus Christi-Memorial (formerly known as Memorial Medical Center) located at 2606 Hospital Boulevard;

Mr. John Michael with Hanson provided an update re: CHRISTUS Spohn Hospital Corpus Christi - Memorial (formerly known as Memorial Medical Center) located at 2606 Hospital Boulevard. Mr. John Michael recommended Nueces County Hospital District to approve contract from Abel's Paving Construction. Copy of the contract is attached hereto and made part of these minutes.

4) Mutual termination of June 12, 2012 Letter Agreement with Health Management Associates, Inc, as amended, relating to consulting services and technical assistance associated with Hospital District's Anchor Entity duties and responsibilities under the Texas Health and Human Services Commission Section 1115 Waiver; termination effective November 1, 2019; and

5) Personal Services Contract with Linda K. Wertz relating to consulting services and technical assistance associated with Hospital District's Anchor Entity duties and responsibilities under the Texas Health and Human Services Commission Section 1115 Waiver; Contract period November 1, 2019 - September 30, 2020.

Contract with Linda K. Wertz for consulting personal services is attached hereto and made part of these minutes.
Board of Managers requested to invite Ms. Linda K. Wertz for a presentation on an update of the personal services contract.
On motion by Mr. Valls and seconded by Ms. Brower to approve Items (5) F, 4-5. MOTION CARRIED.

6. **REGULAR AGENDA:**

A. **Community Mental Health Initiatives:**

1) Receive report from Nueces Center for Mental Health and Intellectual Disabilities (NCMHID) on activities performed under Interlocal Agreement between Nueces County, NCMHID, and Hospital District relating to diversion of persons from jails or other detention facilities, provision of crisis intervention teams, expansion of mobile crisis outreach, and development of

jail-based competency restoration. *(INFORMATION)*

MHID was not in attendance

2) Receive report on activities performed under Professional Services Agreement between Nueces County, BeHealthle, and the Hospital District relating to the Nueces County Community Collaborative Program/Jail Diversion Program. *(INFORMATION)*

An updated report on activities performed under Professional Services Agreement between BeHealthle was presented by Ms. Karla Ramirez. Copy of report is attached hereto and made part of these minutes.

3) Receive reports on activities performed under Professional Services Agreement between Nueces County, Meadows Mental Health Policy Institute, and the Hospital District relating to preparation of a comprehensive needs assessment for Nueces County that can serve as the basis for a systematic approach to providing services for mental illnesses and substance abuse disorders in the County. *(INFORMATION)*

Meadows Foundation was not in attendance.

B. **Indigent Health Care:**

1) Receive reports relating to Nueces Aid Program enrollment for the month ended October 31, 2019. *(INFORMATION)*

Copies of reports relating to Nueces Aid Program are attached hereto and made part of these minutes.

Discussion between Board Members about outreach and advertisement of the Nueces Aid Program. Mr. Hipp stated he would get some information and ideas for the Program. Mr. Martinez stated to move forward at the next Board Meeting.

2) Receive summary information on medical and hospital care provided to the Nueces Aid population consistent with the CHRISTUS Spohn Health System Corporation Membership Agreement for calendar year-to-date ended September 30, 2019. *(INFORMATION)*

Copy of NCHD Imputed Claims Experience for YTD September 30, 2019 is attached and hereto and made a part of these minutes.

3) Receive and discuss information from CHRISTUS Spohn Health System Corporation relating to:
   a) Medical aid and hospital care provided to the Nueces Aid Program population consistent with the CHRISTUS Spohn Health System Corporation Membership Agreement and related matters; and
   b) Programs, projects, and/or activities at CHRISTUS Spohn Hospital Corpus Christi-Memorial and other Hospital District-owned facilities and related matters. *(INFORMATION)*

Copies of the above mentioned reports are attached hereto and made part of these minutes.

4) Receive and discuss update from CHRISTUS Spohn Health System Corporation relating to operation, construction, transition, planning, and/or demolition activities pursuant to Sections 3.5 and 3.9 of Amended and Restated Schedule 1 to Spohn Membership Agreement, as schedule to CHRISTUS Spohn Health System Corporation Amended and Restated Membership Agreement:
   a) Operations of Dr. Hector P. Garcia - Memorial Family Health Center located on Hospital District-owned property at 2606 Hospital Boulevard, Corpus Christi, Texas;
   b) Construction and/or demolition activities at CHRISTUS Spohn Hospital Corpus Christi-Shoreline located at 600 Elizabeth Street, Corpus Christi, Texas;
   c) Transition of certain services from Hospital District-owned hospital presently known as CHRISTUS Spohn Hospital Corpus Christi-Memorial (formerly known as Memorial Medical Center) located at 2606 Hospital Boulevard to CHRISTUS Spohn Hospital Corpus Christi-Shoreline located at 600 Elizabeth Street, both facility locations in Corpus Christi, Texas; and
   d) Planning orderly transition of services from Hospital District-owned hospital presently known as CHRISTUS Spohn Hospital Corpus Christi-Memorial (formerly known as Memorial Medical Center) located at 2606 Hospital Boulevard to CHRISTUS Spohn Hospital Corpus Christi-Shoreline located at 600 Elizabeth Street, both facility locations in Corpus Christi, Texas. *(INFORMATION)*

No update at this time for Section (6) B, 3-4

5) Receive information on potential amendment of Nueces Aid Program Handbook Covered Services Policy NA004, Section IV.G.5-6 relating to

Outpatient Prescription Drug Services; amendment to increase the current prescription maximum for new and refilled prescriptions from 34 to 90 days for each medication. *(INFORMATION)*

Copy of Nueces County Hospital District, Indigent Health Care Program, Policy and Procedure attached hereto and made part of these minutes.

C. **Finance Business:**

1) Receive and approve investment reports and ratify related investment transactions:

a) Quarterly Investment Report for fiscal quarter ended September 30, 2019;

b) Report of interim investment transactions for period October 1, 2019 to date; and

c) Annual Investment Report for fiscal year ended September 30, 2019. *(ACTION)*

Ms. Littlefield presented the Quarterly Investment ending September 30, 2019, Interim Investment Transactions for period October 1, 2019 and the Annual Investment report for FY September 30, 2019.
Copies of above reports are attached hereto and made part of these minutes.

On motion by Mr. Valls and seconded by Dr. Reddy.
MOTION CARRIED.

2) Receive summary report of intergovernmental transfers made in support of local and other healthcare providers participating in Medicaid supplemental payment programs sponsored by the Texas Health and Human Commission from fiscal year ended September 30, 2019:

a) Texas Healthcare Transformation and Quality Improvement Program (Medicaid 1115 Waiver):

(1) Delivery System Reform Incentive Payment (DSRIP) pool; and

(2) Hospital Uncompensated Care (UC) pool.

b) Disproportionate Share Hospitals (DSH) program;

c) Network Access Improvement Program (NAIP);

d) Uniform Hospital Rate Increase Program (UHRIP); and

e) Graduate Medical Education (GME). *(INFORMATION)*

Copies of reports are attached hereto and made part of these minutes.

3) Receive revenue reports relating to CHRISTUS Spohn Health System Corporation Membership Agreement for current Fiscal Year 2020 year-to-date. *(INFORMATION)*

Copies of revenue reports are attached hereto and made part of these minutes.

4) Receive monthly statement of escrow amounts deposited and/or withdrawn by CHRISTUS Spohn Health System Corporation; deposits pursuant to and consistent with Section 3.9.7 of Amended and Restated Schedule 1 to Spohn Membership Agreement, a schedule to CHRISTUS Spohn Health System Corporation Amended and Restated Membership Agreement; receive statements for month ended October 31, 2019. *(INFORMATION)*

Copies of monthly statement of escrow reports are attached hereto and made part of these minutes.

D. **Other Business:**

1) Receive update on initial process for referring potentially qualified Nueces Aid Program enrollees to CHRISTUS Spohn Health System for evaluation toward voluntary enrollment in a health insurance exchange plan offered by CHRISTUS Health Plan. *(INFORMATION)*

Copy of the above mentioned report are attached hereto and made part of these minutes.

2) Approve cooperative contingent fee counsel professional services agreement amongst Nueces County Appraisal District, Corpus Christi Independent School District, City of Corpus Christi, County of Nueces, Del Mar College, and Nueces County Hospital District with Phipps Deacon Purnell PLLC relating to matters associated with property tax litigation for tax years 2018, 2019, and 2020; and authorize Administrator to execute agreement. *(ACTION)*

Mr. Valls presented to the Board information regarding the cooperative contingent fee counsel for professional services

agreement. Mr. Tom Wheat, Attorney presented to the Board the updated fees and expenses relating to the services.
Mr. Alsup explained and updated the Board on the effective date and contingent fee agreement.
Copy of Agreement is attached hereto and made part of these minutes.

Mr. Martinez motioned to approve once the County signs the agreement. On motion by Dr. Reddy and seconded by Ms. Brower to approve contingent on signature and/or approval from the County. All approved for the exception of Mr. Valls who is abstaining from the vote. MOTION CARRIED.

E. **Board of managers Business:**

1) Elect Board of Managers Officers to take office January 1, 2020; elections pursuant to Board of Managers Bylaws, §2.2.A:
   a) Board Chairman; and
   b) Board Vice-Chairman. *(ACTION)*

Mr. Valls on motion nominated Mr. John Martinez to continue as Chairman effective January 1, 2020, Ms. Flores seconded and all Board Members agreed.
Mr. Valls on motion nominated Ms. Oliver to serve as Vice-Chair effective January 1, 2020 and seconded by Dr. Reddy and all Board Members agreed. MOTION CARRIED.

2) Board Chairman Pro Tempore or Chairman-Elect to appoint Chair and members of Standing Board Committees pursuant to Board of Managers Bylaws, §2.5.A:
   a) Quality Management Committee;
   b) Finance Committee; and
   c) Planning Committee. *(ACTION)*

Mr. Martinez stated he will appoint the chair and allow some time for the Chair to decide who they would like to be in their committee's.
Mr. Martinez recommendrd and appointed Mr. Valls for Quality Management Committee, appointed Ms. Brower for Finance Committee and appointed Dr. Reddy for Planning Committee.
On motion by Mr. Valls and seconded by Dr. Reddy.

MOTION CARRIED.

3) Discuss and consider creation of a Special Board Bylaws Review Committee to review the Board's current Bylaws and recommend changes; Committee creation and appointments authorized by Board of Managers Bylaws, §2.5.A.
   a) Create Special Board Bylaws Review Committee; and
   b) Board Chairman Pro Tempore or Chairman-Elect to appoint Committee Chair and members. *(ACTION)*

Mr. Martinez chose the Special Board Committee's and nominated Mr. Dain for the Special Board Bylaws Review Committee.

Mr. Martinez suggested to create a Legislative Committee and for Ms. Flores to be named Chair. Mr. Martinez would like to be able for the Legislative Committee to coordinate with Legislators, County Judge and County Commissioners to make sure goals are aligned. To be discussed on next Board Meeting in December 2019.

On motion by Mr. Valls and seconded by Dr. Reddy. MOTION CARRIED.

4) Confirm 2019 and 2020 Board of Managers Meeting dates. *(ACTION)*

Mr. Martinez presented table to motion on tentative dates for December 2019 meeting. On motion by Mr. Valls and seconded by Ms. Flores. MOTION CARRIED.

5) Adopt dates for tours of Hospital District-owned and selected indigent health care provider facilities. *(ACTION)*

Mr. Martinez presented table to motion on dates for tours On motion by Mr. Valls and seconded by Dr. Reddy MOTION CARRIED.

F. **Administrator's Briefing:**
   1) Future Board of Managers meeting:
      a) Next Scheduled Regular Board Meeting: December 17, 2019, 12 Noon (date/time subject to change).

7. **ADJOURN**

Motion by Ms. Oliver and seconded by Ms. Flores. Meeting adjourned at 3:02 p.m.

PRESIDING OFFICER

_____

John B. Martinez, Chairman Pro Tempore
Nueces County Hospital District

ATTEST:

_____

Jonny F. Hipp, Secretary
Board of Managers
Nueces County Hospital District

_____

Wm Dewitt Alsup, General Counsel
Nueces County Hospital District

Nueces County Hospital District
Vendor Information List - Additional Vendors-Conflict of Interest Disclosure

Vendor ID	Vendor Name	Address	City	State	ZIP
2000	Wertz, Linda K.	119 Dan Moody Trail	Georgetown	TX	78633
2001	Olive Garden	5258 S. Padre Island Drive	Corpus Christi	TX	78411

Nueces County Hospital District
Spohn Corporate Member Revenue Analysis
Fiscal Year 2020

Member Revenue % 26.0%

	October	November	December	January	February	March	April	May	June	July	August	September	Totals
Membership Revenue Deposits													
Week 1	1,691,791.38	1,421,747.32	1,148,315.50										4,261,854.20
Week 2	1,581,019.40	1,833,453.73	1,851,863.04										5,266,336.17
Week 3	1,430,429.37	1,802,592.57											3,233,021.94
Week 4	1,710,724.54	1,907,526.55											3,618,251.09
Week 5													0.00
Subtotal	6,413,964.69	6,965,320.17	3,000,178.54	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	16,379,463.40

Nueces County Hospital District
County Health Care Expenditures
Cash Disbursements Relating to
Fiscal Year 2020

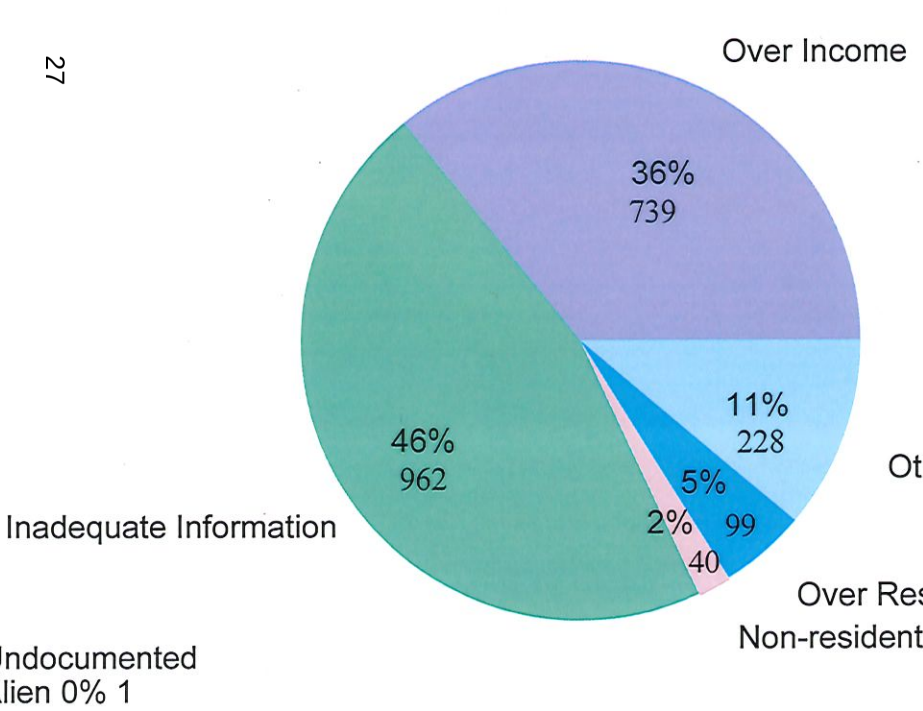
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Fiscal 2020 YTD	Budget 2020	Balance
Health Dept - County	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**591,200.00**	
Health Dept - County - IGT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**1,208,100.00**	1,799,300.00
Emergency Medical Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**500,000.00**	500,000.00
NC MHID - County	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**969,129.00**	969,129.00
NC MHID - Jail Diversion	208,337.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	208,337.00	**2,500,000.00**	2,291,663.00
Juvenile Center - Lab	1,118.50	1,462.18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2,580.68	**355,000.00**	
Juvenile Center - Doctors	21,171.48	21,444.70	1,400.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	44,016.18		
Juvenile Center - Pharmacy	1,249.45	1,574.38	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2,823.83		
Juvenile Center - Other	1,685.73	1,649.82	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3,335.55		
Subtotal	25,225.16	26,131.08	1,400.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	52,756.24	**355,000.00**	302,243.76
Nueces County Jail Services	278,296.33	278,296.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	556,592.66	**3,476,996.00**	2,920,403.34
Cenikor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**55,000.00**	55,000.00
Council on Alcohol & Drug Abuse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**28,714.00**	28,714.00
Palmer Drug Abuse Program	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**5,000.00**	5,000.00
Diabetes Program - County	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**50,000.00**	50,000.00
Totals	511,858.49	304,427.41	1,400.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	817,685.90	**9,739,139.00**	8,921,453.10

NUECES AID DENIALS

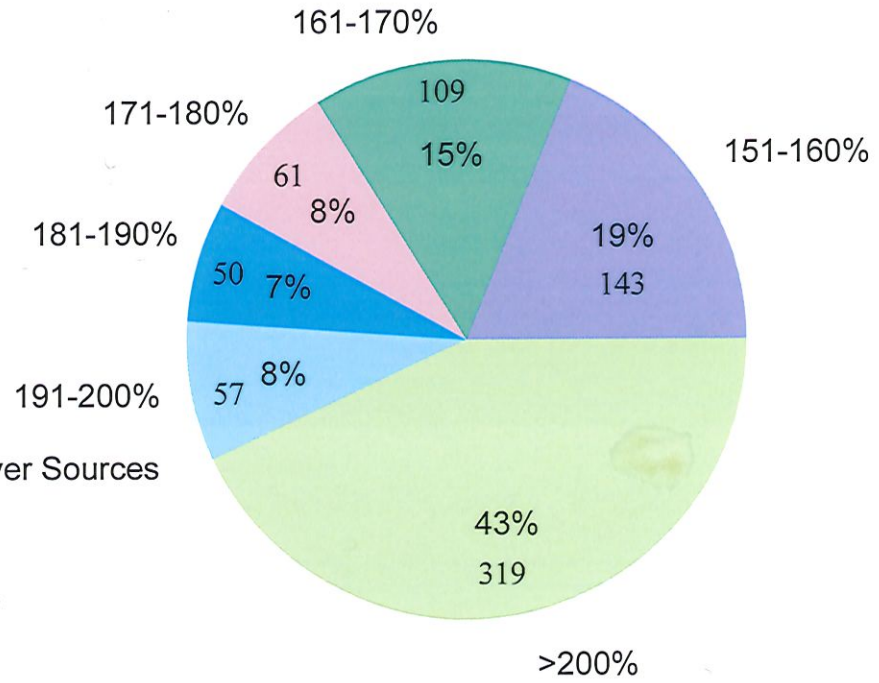
Calendar Year 2019
January-November

Total Denials 2,069

Denial Reasons



Comparison of Over Income Cases to 2019 HHS Poverty Guidelines



Nueces Aid Program
Application Processing Summary Calendar Year 2019

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD 2019	Comments
TOTAL APPLICATIONS	1,363	1,074	1,185	1,191	1,151	1,105	1,108	1,158	1,132	1,324	964		12,755	
- Approved	1,140	848	998	1,000	983	918	936	991	947	1,131	794		10,686	
%	83.6%	79.0%	84.2%	84.0%	85.4%	83.1%	84.5%	85.6%	83.7%	85.4%	82.4%		83.8%	Since FY 1999, the denial rate is based on all denied
- Denied	223	226	187	191	168	187	172	167	185	193	170		2,069	individuals in the household.
%	16.4%	21.0%	15.8%	16.0%	14.6%	16.9%	15.5%	14.4%	16.3%	14.6%	17.6%		16.2%	
APPROVALS BY PLAN TYPE														
NUECES AID - All Services														
100%	738	570	647	665	672	596	618	663	636	746	542		7,093	
%	64.7%	67.2%	64.8%	66.5%	68.4%	64.9%	66.0%	66.9%	67.2%	66.0%	68.3%		66.4%	
90%	42	40	33	42	54	33	28	45	31	46	26		420	
%	3.7%	4.7%	3.3%	4.2%	5.5%	3.6%	3.0%	4.5%	3.3%	4.1%	3.3%		3.9%	
80%	47	27	53	39	36	37	30	32	38	44	29		412	
%	4.1%	3.2%	5.3%	3.9%	3.7%	4.0%	3.2%	3.2%	4.0%	3.9%	3.7%		3.9%	
70%	40	30	44	32	32	30	39	39	27	47	29		389	The percentage of approvals
%	3.5%	3.5%	4.4%	3.2%	3.3%	3.3%	4.2%	3.9%	2.9%	4.2%	3.7%		3.6%	by plan option is calculated by dividing the number for
60%	32	18	18	17	17	30	33	21	27	27	22		262	each plan option by the
%	2.8%	2.1%	1.8%	1.7%	1.7%	3.3%	3.5%	2.1%	2.9%	2.4%	2.8%		2.5%	total number of approved applications.
50%	34	21	23	31	16	26	24	15	26	27	12		255	
%	3.0%	2.5%	2.3%	3.1%	1.6%	2.8%	2.6%	1.5%	2.7%	2.4%	1.5%		2.4%	
TOTAL	933	706	818	826	827	752	772	815	785	937	660		8,831	
%	81.8%	83.3%	82.0%	82.6%	84.1%	81.9%	82.5%	82.2%	82.9%	82.8%	83.1%		82.6%	
HOUSEHOLDS BY SIZE - APPROVED														
1 Member Household	983	745	850	849	838	794	831	859	807	963	703		9,222	The percentage for each size
%	92.5%	93.5%	91.9%	91.8%	92.0%	92.6%	93.9%	92.7%	91.9%	91.8%	93.9%		92.5%	household is calculated by dividing the number of house-
2 Member Household	77	51	71	74	73	62	51	64	68	81	44		716	holds in the category by the
%	7.2%	6.4%	7.7%	8.0%	8.0%	7.2%	5.8%	6.9%	7.7%	7.7%	5.9%		7.2%	total number of approved households.
3 or > Member Household	3	1	4	2	0	1	3	4	3	5	2		28	Households pending other
%	0.3%	0.1%	0.4%	0.2%	0.0%	0.1%	0.3%	0.4%	0.3%	0.5%	0.3%		0.3%	payors are not included.
TOTAL HOUSEHOLDS APPROVED	1,063	797	925	925	911	857	885	927	878	1,049	749		9,966	

Nueces Aid Program
Application Processing Summary Calendar Year 2019

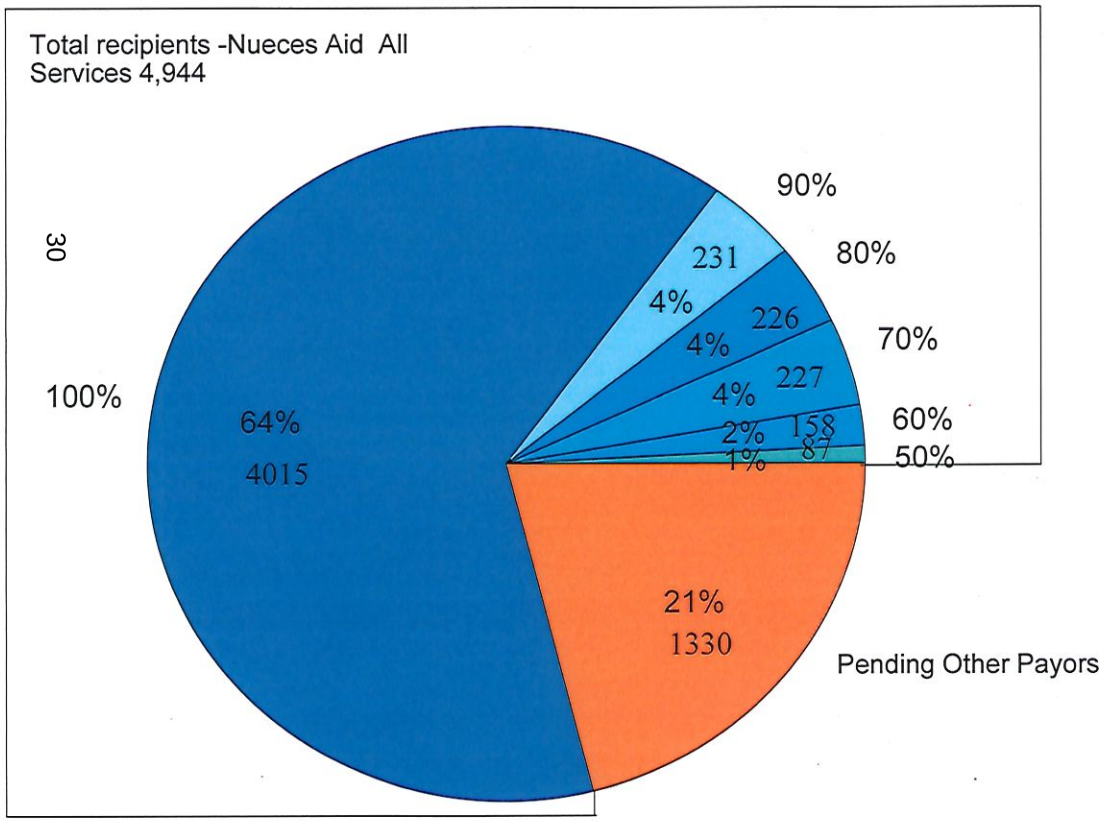
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD 2019	Comments
NCHD DENIALS - Reasons for Denials														
Non Resident	7	4	4	2	2	2	5	5	4	4	1		40	The percentage for each
%	3.1%	1.8%	2.1%	1.0%	1.2%	1.1%	2.9%	3.0%	2.2%	2.1%	0.6%		1.9%	denial reason is calculated by dividing the number of
Over Income	88	110	57	60	44	67	51	73	59	68	62		739	individuals for each reason
%	39.5%	48.7%	30.5%	31.4%	26.2%	35.8%	29.7%	43.7%	31.9%	35.2%	36.5%		35.7%	by the total number of individuals denied.
Over Resources	7	8	6	16	8	11	7	6	15	11	4		99	
%	3.1%	3.5%	3.2%	8.4%	4.8%	5.9%	4.1%	3.6%	8.1%	5.7%	2.4%		4.8%	
Other Payer	30	16	23	25	19	18	22	18	22	15	20		228	
%	13.5%	7.1%	12.3%	13.1%	11.3%	9.6%	12.8%	10.8%	11.9%	7.8%	11.8%		11.0%	
Incomplete Info	91	88	97	88	95	89	87	65	84	95	83		962	
%	40.8%	38.9%	51.9%	46.1%	56.5%	47.6%	50.6%	38.9%	45.4%	49.2%	48.8%		46.5%	
Undocumented Aliens	0	0	0	0	0	0	0	0	1	0	0		1	Note: UA code eff 08/01/01
%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%		0.0%	
TOTAL DENIALS	223	226	187	191	168	187	172	167	185	193	170		2,069	
HOUSEHOLDS BY SIZE - DENIED														
1 Member Household	170	161	140	150	135	151	134	133	145	144	132		1595	The denial percentage for
%	86.3%	83.4%	85.4%	87.7%	88.8%	89.3%	87.6%	88.1%	87.9%	85.2%	86.8%		86.9%	each size household is calculated by dividing the
2 Member Household	27	30	23	19	17	18	19	17	19	25	19		233	number for each household
%	13.7%	15.5%	14.0%	11.1%	11.2%	10.7%	12.4%	11.3%	11.5%	14.8%	12.5%		12.7%	size by the total number of denied households.
3 or > Member Household	0	2	1	2	0	0	0	1	1	0	1		8	Households pending other
%	0.0%	1.0%	0.6%	1.2%	0.0%	0.0%	0.0%	0.7%	0.6%	0.0%	0.7%		0.4%	payors are not included.
TOTAL HOUSEHOLDS DENIED	197	193	164	171	152	169	153	151	165	169	152		1,836	
PENDING APPLICATIONS														The YTD number for incomplete applications is
Incomplete Applications	105	130	120	111	111	109	103	101	133	133	84		113	the average of the monthly incomplete applications.
TANF	36	29	27	29	36	36	18	32	26	50	34		34	
SSI-SSID	93	60	89	80	62	71	75	71	68	71	57		57	
Other Payor	78	53	64	65	58	59	71	73	68	73	43		43	

November 2019

Nueces Aid Program Enrollment

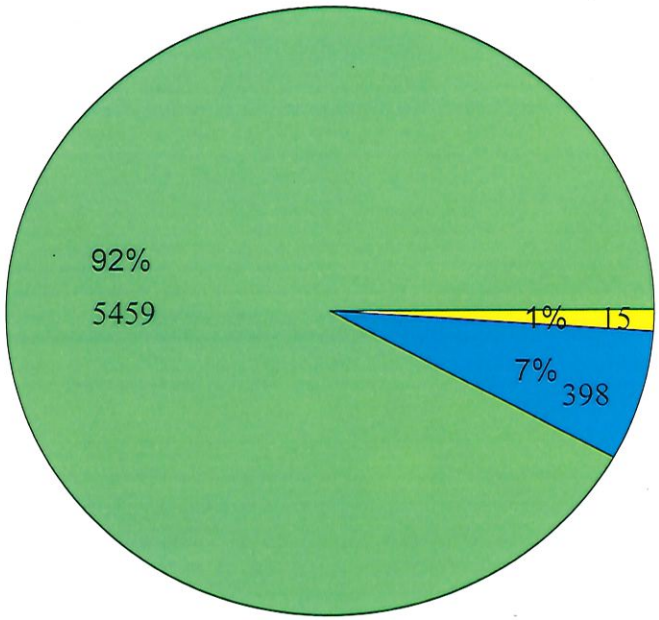
Total Enrolled

6,274



Total Households

5,872



1 Member

2 Members

>3 Members

Nueces Aid Program
Enrollment Summary Calendar Year 2019

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD 2019 Average	Comments
TOTAL RECIPIENTS	6,571	6,441	6,364	6,329	6,231	6,242	6,326	6,299	6,309	6,421	6,274		6,346	
NUECES AID - All Services														The percentage for each plan option is calculated by dividing the number for each option by the number of total recipients.
100%	4,286	4,183	4,083	4,028	3,984	3,980	3989	3960	3982	4068	4015		4,051	
%	65.2%	64.9%	64.2%	63.6%	63.9%	63.8%	63.1%	62.9%	63.1%	63.4%	64.0%		63.8%	
90%	249	263	255	238	245	246	245	242	241	240	231		245	
%	3.8%	4.1%	4.0%	3.8%	3.9%	3.9%	3.9%	3.8%	3.8%	3.7%	3.7%		3.9%	
80%	256	251	249	254	242	245	242	232	239	235	226		243	
%	3.9%	3.9%	3.9%	4.0%	3.9%	3.9%	3.8%	3.7%	3.8%	3.7%	3.6%		3.8%	
70%	218	216	222	226	215	208	217	226	218	225	227		220	
%	3.3%	3.4%	3.5%	3.6%	3.5%	3.3%	3.4%	3.6%	3.5%	3.5%	3.6%		3.5%	
60%	157	152	146	145	140	141	156	149	152	157	158		150	
%	2.4%	2.4%	2.3%	2.3%	2.2%	2.3%	2.5%	2.4%	2.4%	2.4%	2.5%		2.4%	
50%	111	116	120	133	131	141	147	134	138	139	87		127	
%	1.7%	1.8%	1.9%	2.1%	2.1%	2.3%	2.3%	2.1%	2.2%	2.2%	1.4%		2.0%	
TOTAL NUECES AID	5,277	5,181	5,075	5,024	4,957	4,961	4,996	4,943	4,970	5,064	4,944		5,036	
	80.3%	80.4%	79.7%	79.4%	79.6%	79.5%	79.0%	78.5%	78.8%	78.9%	78.8%		79.4%	

Nueces Aid Program
Enrollment Summary Calendar Year 2019

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD 2019 Average	Comments
PENDING OTHER PAYORS														
TANF	106	108	106	106	100	100	100	110	95	112	131		107	
%	8.2%	8.6%	8.2%	8.1%	7.8%	7.8%	7.5%	8.1%	7.1%	8.3%	9.8%		8.1%	
SSI-SSID	790	766	791	799	777	778	809	818	805	794	786		792	
%	61.1%	60.8%	61.4%	61.2%	61.0%	60.7%	60.8%	60.3%	60.1%	58.5%	59.1%		60.4%	These individuals are eligible for NCHD assistance if
Other Payor	398	386	392	400	397	403	421	428	439	451	413		412	denied assistance by other
%	30.8%	30.6%	30.4%	30.7%	31.2%	31.5%	31.7%	31.6%	32.8%	33.2%	31.1%		31.4%	payer.
TOTAL PENDING OTHER PAYORS	1,294	1,260	1,289	1,305	1,274	1,281	1,330	1,356	1,339	1,357	1,330		1,310	
	19.7%	19.6%	20.3%	20.6%	20.4%	20.5%	21.0%	21.5%	21.2%	21.1%	21.2%		20.6%	
HOUSEHOLDS BY SIZE														
1 Member Household	5,693	5,604	5,526	5,492	5,373	5,393	5,482	5,446	5455	5541	5459		5,497	The percentage for each size
%	92.7%	93.0%	92.8%	92.8%	92.5%	92.6%	92.2%	92.7%	92.7%	92.6%	93.0%		92.7%	household is calculated by dividing the number of each
2 Member Household	429	411	411	409	421	418	452	418	418	431	398		420	member household by the
%	7.0%	6.8%	6.9%	6.9%	7.2%	7.2%	7.6%	7.1%	7.1%	7.2%	6.8%		7.1%	total number of households.
>=3 Member Household	18	14	15	17	14	10	9	13	13	15	15		14	
%	0.3%	0.2%	0.3%	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%	0.3%	0.3%		0.2%	
TOTAL HOUSEHOLDS	6,140	6,029	5,952	5,918	5,808	5,821	5,943	5,877	5,886	5,987	5,872		5,930	

Nueces County Hospital District
Imputed Claims Experience for Calendar Year 2019
As if Adjudicated January 1, 2019 through November 30, 2019

Service	Claims	Billed	Contract Amt.	Co Insurance	Net
ER	5,484	24,551,392	3,251,701	145,826	3,105,875
ASU	833	14,124,215	1,221,373	66,743	1,154,630
Clinic	21,703	12,547,276	3,442,323	203,953	3,238,370
Obs	235	6,388,258	1,317,897	109,173	1,208,724
OP	11,547	28,155,097	7,394,320	557,952	6,836,368
Subtotal	39,802	85,766,238	16,627,614	1,083,647	15,543,967
IP	750	47,253,061	7,428,461	373,906	7,054,555
SNF	12	658,074	66,207	4,686	61,521
RX	141,343	42,902,169	17,521,233	721,464	16,799,769
Physician	42,623	12,590,488	3,956,603	227,219	3,729,384
Total	224,530	189,170,030	45,600,118	2,410,922	43,189,196

NOTE:

The Revised and Restated Indigent Care Agreement was terminated effective September 30, 2012. After that date, the District no longer makes payment to CHRISTUS Spohn for providing health care services to the Nueces Aid Indigent population. Under the terms of the Membership Agreement amended and restated effective November 18, 2015, CHRISTUS Spohn has committed to continue to provide health care services to the Nueces Aid Indigent population and, and at the request of the District, continues to submit informational claims to the District to permit the District to monitor the volume of health care services furnished to the Nueces Aid Indigent population.

BANK DEPOSITORY AGREEMENT

This depository agreement for public fund entities, together with the terms of the BANK's RFA response to serve as depository, a copy of which is attached hereto, if applicable (collectively, this "Agreement"), is made and entered into on the date last herein written by and between **Nueces County Hospital District**, hereinafter called "DEPOSITOR," and FROST BANK, a Texas state bank, duly organized and authorized by law to do banking business in the State of Texas and now carrying on such business in said State (the "BANK").

1. **Appointment of Depository and Term.**

DEPOSITOR designates BANK as a depository for the period beginning **December 1, 2019** and continuing until this Agreement has been canceled in accordance with the provisions hereof, for certain accounts in the name of the DEPOSITOR, and such accounts shall be opened by the DEPOSITOR designating the accounts and making deposits therein and the BANK accepting said deposits. The term of this Agreement (the "Term") shall be **for a period of forty-six (46) months, commencing December 1, 2019 and continuing through September 30, 2023** as defined in the **Nueces County Hospital District's**'s Request for Application, unless the parties mutually agree to an extension of the Term of this Agreement if such extension is allowed by applicable law. If the parties agree to such an extension of the Term, then the parties shall either execute an addendum to this Agreement or other written evidence stating that the parties have agreed to an extension, the statutory or other legal authority for such extension and the date upon which such extension of the Term expires. The parties will comply with Section 116.021 of the Government Code.

During the Term of this Agreement, the DEPOSITOR will, through appropriate action of its governing body, designate the officer or officers who, individually or jointly, will be authorized to represent and act on behalf of the DEPOSITOR in any and all matters of every kind arising under this Agreement, including, but not limited to, taking such actions as: (a) executing and delivering to BANK an electronic fund or funds transfer agreement (and any addenda thereto); (b) appointing and designating, from time to time, a person or persons authorized to request withdrawals, orders for payment, or transfers on behalf of DEPOSITOR in accordance with the electronic fund or funds transfer agreement and addenda; (c) making withdrawals or transfers by written instrument; and (d) delivering to BANK the DEPOSITOR's collateral policy and evidence of approval by the DEPOSITOR's governing body of (1) the collateral policy, (2) the CUSTODIAN (defined below), (3) this Agreement, and (4) the attached Security Agreement (defined below).

2. **Establishment of Accounts.**

DEPOSITOR shall deposit such of its funds as it may choose, and BANK shall receive such deposits as "Demand Deposits," Interest on Checking Accounts ("IOCs"), "Savings Accounts," Money Management Accounts ("MMAs"), and/or Certificates of Deposit ("CDs"), as designated by DEPOSITOR, and BANK shall hold said Demand Deposits, IOCs, Savings Accounts, MMAs, and/or CDs subject to payment in accordance with the terms of the particular deposit. BANK will allow, credit, and pay interest on such IOCs, Savings Accounts, MMAs, and/or CDs at a rate to be set by the BANK, with: (1) interest on IOCs and MMAs to be paid monthly as it accrues through the last day of each month; (2) interest on Savings Accounts to be paid quarterly as it accrues through the last day each quarter; and (3) interest on CDs to be paid at maturity. Interest on CDs shall be calculated for the exact number of days on the basis of

a 365-day year. All BANK accounts or products listed above shall be in the name of Depositor with the designation of the fund or account in accordance with instructions of Depositor.

3. **Depository Services; DEPOSITOR Records; Fees.**

Subject to the provisions stated above and to the particular terms of MMAs, Savings Accounts, or IOCs, BANK shall pay on demand to the order of DEPOSITOR upon presentation of checks, drafts, or vouchers properly issued, all or any portion of said deposits now on deposit or to be deposited with said BANK, as long as collected funds are on deposit.

BANK statements, check images, check registers, deposit slips, debit and credit notices, reconciliations, notices of interest earned, and any other related documentation, or images thereof, shall be retained by BANK for a period of 7 years after the date of receipt of the items. To the extent permitted by law, BANK shall make all records, books, and supporting documents, or images thereof, pertaining to services applicable to DEPOSITOR accounts and transactions pursuant to this Agreement available at any reasonable time during the term of this Agreement, to DEPOSITOR and its designated representatives. To the extent permitted by law, DEPOSITOR shall have the right to examine, audit, inspect, or make copies of any of such documents.

To determine charges for services rendered, BANK utilizes an earnings credit rate on BANK's account analysis system, determined and calculated in a manner specified in the BANK's proposal/offer. The BANK's account analysis system is used to calculate and account for all BANK-performed deposit and treasury management service charges. BANK will calculate the DEPOSITOR's combined average daily collected balances less combined average daily Federal Reserve requirements, and using the earnings credit rate, number of days in the year, and number of days in the month calculate the earnings credit of the BANK and use those earnings credit to offset the charges to the DEPOSITOR of combined services rendered by BANK. For any amount of charge of services not offset by DEPOSITOR's earnings credit as described above, DEPOSITOR shall remit payment in such amount to BANK monthly. Any excess available balance can be carried to the next month for service compensation. Excess balances must be used for compensation on a quarterly basis (March, June, September and December). Any interest paid on IOCs, Savings Accounts, or MMAs is considered an expense on the account analysis statement.

4. **Security of Funds; Acceptable Security; Appointment of CUSTODIAN; Increases in Collateral Amounts.**

All funds on deposit with BANK to the credit of the DEPOSITOR (including Demand Deposits, IOCs, Savings Accounts, MMAs, and CDs) shall be secured pursuant to the BANK's "Security Agreement" or similar agreement (the "Security Agreement") and any agreement required by the CUSTODIAN (defined below), all of which are attached hereto.

DEPOSITOR and BANK, by execution of this Agreement, designate Federal Reserve Bank, Federal Home Loan Bank or The Bank of New York Mellon Trust Company, N.A. as the "CUSTODIAN," to hold collateral in an account maintained by CUSTODIAN in the name of the BANK and subject to the control of DEPOSITOR, according to the terms and conditions of this Agreement, the Security Agreement, and any agreement required by the CUSTODIAN to document such relationship.

DEPOSITOR recognizes that the Federal Deposit Insurance Corporation (or its successor) (the "FDIC") provides insurance for DEPOSITOR's funds deposited at any one Texas financial institution, including accrued interest on such funds, only up to maximum regulatory limits as set by the FDIC. All uninsured funds on deposit with BANK to the credit of the DEPOSITOR shall be secured by collateral as provided for in the Texas Public Funds Collateral Act and in other applicable law (collectively, the "Acts"), and DEPOSITOR agrees and certifies that the collateral listed in Exhibit A to the Security Agreement shall be eligible to be used as collateral to secure DEPOSITOR's funds on deposit with the BANK. The market value of the collateral securing DEPOSITOR's funds must at all times equal or exceed 102% of the daily ledger balance (amount of funds plus the amount of any accrued interest on the funds) of all DEPOSITOR's Demand Deposits, IOC's, Savings Accounts, MMA's and CDs, less the FDIC standard

maximum deposit insurance amount ("SMDIA") (the "Collateral Requirement"). The market value with respect to any collateral as of any date and priced on such date will be obtained by the BANK from a generally recognized pricing source.

When the need for collateral with the BANK is expected to increase on any given day or over a series of days, DEPOSITOR agrees to notify the BANK of such expected increase at least 1 business day prior to the expected date the additional deposits are expected to be received.

5. Delivery of Collateral to CUSTODIAN.

BANK already, or will immediately after the effective date of this Agreement, deliver to CUSTODIAN collateral of the kind and character above mentioned of sufficient amount and market value to provide adequate collateral for the uninsured funds (as described in Section 4 above) of DEPOSITOR deposited with BANK. Such collateral or substitute collateral (as discussed below), shall be kept and retained by CUSTODIAN in an account maintained in the name of BANK and subject to the control of DEPOSITOR pursuant to the terms of this Agreement and of the Security Agreement, so long as the depository relationship between DEPOSITOR and BANK shall exist, and after the termination or expiration of this Agreement so long as any portion of the deposits made by DEPOSITOR with BANK shall have not been properly paid out by BANK to DEPOSITOR or on its order. The BANK grants a security interest in such collateral to DEPOSITOR. The joint custody account at the Federal Reserve Bank, Federal Home Loan Bank or The Bank of New York Mellon Trust Company, N.A. will be held in the BANK's and DEPOSITOR's name.

6. Custodian Safekeeping Account.

The BANK shall cause CUSTODIAN to accept said collateral and hold the same in trust for the purposes stated in this Agreement, in a separate joint safekeeping account with the CUSTODIAN, the DEPOSITOR, and the BANK, to be managed pursuant to the Security Agreement, and the operating agreements, guidelines, and procedures as stated in this Agreement and pursuant to the terms of any separate agreement with the CUSTODIAN.

7. Duties and Liabilities of CUSTODIAN.

It is distinctly understood by all the parties that the CUSTODIAN shall not be required to ascertain the amount of funds on deposit by the DEPOSITOR with BANK, nor the validity, authenticity, genuineness, or negotiability of the securities deposited with the CUSTODIAN by BANK pursuant to this Agreement, and the CUSTODIAN is not liable to anyone for performing in accordance with this Agreement, except for the safekeeping of the securities delivered to Custodian, and for any negligence, gross negligence or willful misconduct of CUSTODIAN's own officers, agents, and employees.

8. Right of DEPOSITOR Upon BANK'S Breach of Duties Under Agreement or BANK'S Insolvency.

Should BANK fail at any time to pay immediately and satisfy upon proper presentation any check, draft, or voucher lawfully drawn upon any Demand Deposit, or fail at any time upon proper presentation or authorization to pay and satisfy, when due, any check, draft, or voucher lawfully drawn against any IOC, MMA, or Savings Account and the interest on such IOC, MMA, or Savings Account, or in case BANK becomes insolvent or in any manner breaches its contract with DEPOSITOR, it shall be the duty of the CUSTODIAN, upon the demand of DEPOSITOR (in DEPOSITOR's sole discretion, and supported by proper evidence of any of the above listed circumstances), to surrender the above-described collateral to DEPOSITOR. DEPOSITOR may, in accordance with the terms of this Depository Agreement and any applicable provisions of a Security Agreement, sell all or any part of such collateral, and out of the proceeds of such sale deduct for itself payment of all damages and losses sustained by it, together with all expenses of any kind and every kind incurred by DEPOSITOR on account of such breach, failure or insolvency, accounting to BANK for the remainder, if any, of such proceeds or collateral remaining unsold.

9. **Collateral Substitutions by BANK.**

If BANK shall desire to sell or otherwise dispose of any one or more of such collateral so deposited with the CUSTODIAN, it may, with prior approval of DEPOSITOR, substitute for any one or more of such collateral other collateral of the same market value and of the character authorized in this Agreement, and such right of substitution shall remain in full force and be exercised by BANK as often as it may desire to sell or otherwise dispose of any such collateral; provided, however, that at all times, the aggregate amount of such collateral or substituted collateral deposited with the CUSTODIAN shall always be such that it meets the Collateral Requirement. If at any time the aggregate amount of such collateral so deposited with the CUSTODIAN is less than the Collateral Requirement, then in that event, BANK shall immediately deposit with the CUSTODIAN additional collateral as may be necessary to meet the Collateral Requirement.

BANK shall be entitled to income on collateral held by the CUSTODIAN, and the CUSTODIAN may dispose of such income as directed by BANK without approval of DEPOSITOR, to the extent such income is not needed to secure DEPOSITOR's deposits, and provided that retention of such income does not otherwise violate this Agreement.

10. **Trust Receipts For Collateral; DEPOSITOR'S Right To Itemized List of Collateral.**

BANK shall cause CUSTODIAN to promptly forward to DEPOSITOR trust receipts via regular mail, or will provide such trust receipts and reporting on the Nexen Internet service made available to DEPOSITOR, covering all such collateral held for DEPOSITOR by CUSTODIAN, including substitute collateral substituted in accordance with this Agreement. BANK shall also maintain records relating to all such collateral held for the benefit of DEPOSITOR. Upon written request of the DEPOSITOR, and if in accordance with the CUSTODIAN's agreement, the BANK shall request that the CUSTODIAN furnish as of any date requested a completely itemized list of collateral held as security for DEPOSITOR.

11. **Collateral Value In Excess of Collateral Requirement.**

If at any time the collateral held by the CUSTODIAN for the benefit of the DEPOSITOR has a market value in excess of the Collateral Requirement, then upon the written authorization of an authorized representative of the BANK, confirmed by an authorized representative of the DEPOSITOR, the BANK may request withdrawal of a specified amount of collateral, the CUSTODIAN shall deliver this amount of collateral (and no more) to BANK, and the CUSTODIAN shall have no further liability for collateral so redelivered to BANK.

All substitutions, releases, and additional pledges of collateral pursuant to the terms hereof and of the Security Agreement shall be completed at the earliest time as is commercially reasonable.

12. **Termination; Amendment of Agreement.**

Either DEPOSITOR or BANK shall have the right to terminate this Agreement prior to the expiration date by providing the other party with 90 days prior written notice of its election to terminate. The Agreement shall terminate 90 days after delivery of such written notice, provided that all provisions of this Agreement have been fulfilled.

In addition to any other remedy that DEPOSITOR may have at law or in equity, if BANK breaches this Agreement in any manner or defaults on its obligations hereunder and does not cure such breach or default within 30 days of BANK receiving notice of such breach or default from DEPOSITOR, then after expiration of such 30 day cure period, DEPOSITOR may terminate this Agreement and withdraw its funds by giving BANK written notice of termination and withdrawal. Both BANK and DEPOSITOR agree that among other items constituting default under this Agreement is a failure to maintain adequate collateral or adequate capital ratios (if applicable).

In the event that DEPOSITOR fails to comply with any of its promises in this Agreement, or if any of its representations are untrue or any of its warranties is breached, and DEPOSITOR does not cure such breach or default within 30 calendar days of DEPOSITOR receiving notice of such breach or default from BANK, then after expiration of such 30 calendar day cure period, BANK may terminate this Agreement by sending written notice to DEPOSITOR of BANK's decision to terminate. Upon receipt of such notice, DEPOSITOR shall make provisions for the immediate withdrawal of DEPOSITOR's funds from BANK.

This Agreement may be amended in a writing executed by both the DEPOSITOR and the BANK.

13. Post-Termination/Expiration Obligations.

When the relationship of DEPOSITOR and BANK shall have ceased to exist, and when BANK shall have properly paid out all deposits of DEPOSITOR, it shall be the duty of DEPOSITOR to give the CUSTODIAN a certificate to that effect. Upon CUSTODIAN's receipt of such certificate, the CUSTODIAN shall redeliver to BANK all collateral then in its possession belonging to BANK for the benefit of DEPOSITOR, and taking its receipt for such delivery. An order in writing presented to the CUSTODIAN by DEPOSITOR and a receipt for such collateral by BANK shall constitute a full and final release of the CUSTODIAN of all its duties and obligations under this Agreement, and the CUSTODIAN shall not have any liability of any kind whatsoever to both DEPOSITOR and BANK, except for any liability as set forth in Section 7 above where such liability arose while the collateral was in CUSTODIAN's control.

14. Representations and Warranties of the Parties.

The BANK represents and warrants that:

(a) the BANK is the sole legal and actual owner of the securities or of a beneficial interest in the securities utilized to collateralize deposits;

(b) other than the security interest granted to DEPOSITOR herein, no other security interest has been, nor will be, granted in the securities utilized to collateralize deposits;

(c) BANK accounts are insured to the regulatory limits of the FDIC;

(d) this Agreement has been approved by the BANK's Board of Directors, and such approval is evidenced by a true and correct copy of the resolution of BANK's Board of Directors adopted at the meeting at which this Agreement was approved (attached to this Agreement and incorporated for all purposes), and further, such approval is reflected in the minutes of such meeting of the Board of Directors; and

(e) this Agreement is an official record of the BANK, and has been, and will continue to be, an official record of the BANK from the date of its approval by the BANK's Board of Directors.

The DEPOSITOR represents, warrants and promises that:

(a) the DEPOSITOR has complied with all applicable law governing the selection of a depository bank, that DEPOSITOR has full power and authority to enter into this Agreement, the Agreement is a valid and binding agreement enforceable against the DEPOSITOR pursuant to its terms, and does not and will not violate any statute or regulation applicable to DEPOSITOR;

(b) all acts, conditions, and things required to exist, happen, or to be performed on DEPOSITOR's part precedent to and in the execution and delivery of this Agreement exist or have happened or have been performed; and

(c) DEPOSITOR will comply with the terms of any other agreements it may have with BANK in connection with this Agreement.

15. Incorporation of Request for Application and Response; Conflicting Provisions.

The DEPOSITOR's Request for Application dated **June 25, 2019** ("RFA"), and the BANK's response to the DEPOSITOR's Request for Application, dated **July 19, 2019** ("Response"), are incorporated into this Agreement by reference. In the event of any conflicts between the RFA and the Response, the provisions of the RFA control. In the event of any conflicts between the Response and this Agreement regarding provisions and topics addressed in both documents, the provisions of this Agreement control. In the event of any provisions and topics addressed in the Response and not addressed in this Agreement, the Response controls.

16. Liability of the Parties.

The BANK's and DEPOSITOR's duties and responsibilities to each other are limited as set forth in this Agreement, except with respect to any provisions of the law which cannot be varied or waived by agreement. **TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, NEITHER BANK NOR DEPOSITOR WILL BE LIABLE FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY, SPECIAL, OR PUNITIVE DAMAGES (INCLUDING WITHOUT LIMITATION, LOSS OF REVENUE OR ANTICIPATED PROFITS), OR FOR ANY INDIRECT LOSS THAT THE OTHER PARTY MAY INCUR OR SUFFER IN CONNECTION WITH THE SERVICES PROVIDED HEREUNDER (EVEN IF THE SUCH PARTY HAS BEEN INFORMED OF THE POSSIBILITY OF SUCH DAMAGES), INCLUDING WITHOUT LIMITATION, ATTORNEYS' FEES.**

17. Invalidity; Severability.

If any clause or provision of this Agreement is for any reason held to be invalid, illegal, or unenforceable, such holding shall not affect the validity, legality, or enforceability of the remaining clauses or provisions of this Agreement.

18. Governing Law; Venue.

This Agreement shall be construed in accordance with the substantive laws of the State of Texas, without regard to conflicts of law principles thereof. BANK and DEPOSITOR consent to the non-exclusive jurisdiction of a state or federal court situated in **Nueces** County, Texas, in connection with any dispute arising from or relating to this Agreement. BANK and DEPOSITOR irrevocably waive, to the fullest extent permitted by applicable law, any objection which it may now or hereafter have to the laying of venue of any such proceeding brought in such a court and any claim that such proceeding brought in such a court has been brought in an inconvenient forum. BANK and DEPOSITORY each irrevocably waives any and all rights to trial by jury in any legal proceeding arising out of or relating to this Agreement.

19. Notices.

Any communication, notice, or demand to be given hereunder shall be duly given when delivered in writing or sent by telex or facsimile to a party at its address indicated below.

If to the DEPOSITOR:

Jonny F. Hipp, ScD, FACHE; Administrator / Chief Executive Officer
Nueces County Hospital District
555 North Carancahua St.; Suite #950
Corpus Christi, Texas 78401-0835
Jonny.Hipp@nchdcc.org

If to BANK:

Daniel Nash; Public Finance
Frost Bank
501 S. Shorleline
Corpus Christi, Texas 78401
Daniel.Nash@FrostBank.com

20. Security Measures.

BANK and DEPOSITOR agree to implement and follow mutually agreeable and adequate measures to protect the privacy and security of DEPOSITOR's transactions and information, including communications and information held by DEPOSITORY or BANK, or transmitted between DEPOSITOR and BANK. These measures may set forth in various BANK service-specific agreements or documentation, and shall address such issues as: (1) signature and identity verification; (2) fraud detection, prevention and reporting; (3) security codes and similar controls; (4) transmittal procedures and prior and proper authorization of telecopy, telephone, electronic and other transactions; (5) e-commerce issues such as encryption, e-mail security, and website security; and (6) computer and other access controls. BANK shall provide DEPOSITOR with at least 30 days prior written notice of any changes or amendments to the Bank's security procedures, as described in this Section 20 and elsewhere in this Agreement or other BANK service-specific agreements or documents, unless such changes or amendments must, in BANK'S sole opinion and discretion, be made: (i) immediately in order to guard against or mitigate a risk of fraud or criminal activity; or (ii) immediately to comply with an order or directive from law enforcement, court of law or any other regulatory agency with authority over the BANK's activities and operations.

21. Assignment and Binding Effect; Amendment.

The DEPOSITOR may not assign all or any part of its rights or obligations under the Agreement without the BANK's prior express written consent, which may be withheld in the BANK's sole discretion. The BANK may not assign or delegate all or any part of its rights or obligations under the Agreement, including, without limitation, the performance of the services described herein without the DEPOSITOR'S prior express written consent, which may be withheld in DEPOSITOR'S sole discretion except in the event of a sale, purchase or acquisition of the Bank. The Agreement will be binding on and inure to the benefit of the successors and permitted assigns of either party.

22. Third Party Service Providers.

In the normal course of its business, BANK may engage third party vendors or subcontractors to provide or assist in providing all or part of certain services. In the event that BANK engages such third party vendors or subcontractors, any contracts that BANK enters into with such third party vendors or subcontractors for the assistance in providing services under this Agreement shall contain necessary clauses requiring such third party vendors or subcontractors to comply with the provisions of this Agreement, including, but not limited to, levels of performance, service and data security. Any third party vendor or subcontractor used by BANK is an independent contractor and not the BANK's agent. This Agreement may not be amended or modified in any manner except by written agreement executed by all of the parties.

23. Records, Reports and Audits.

BANK shall maintain separate, accurate and complete records relating to the DEPOSITOR's funds, the pledged securities and all transactions relating to the pledged securities. BANK will also take reasonable steps to insure that the CUSTODIAN shall maintain separate, accurate and complete records relating to the pledged securities and all transactions relating to the pledged securities. DEPOSITOR and its representatives or agents shall have the right to examine and audit at any reasonable time upon 5 days prior written notice all records maintained pursuant to this Section 23.

IN WITNESS WHEREOF, the BANK and DEPOSITOR have caused this Agreement to be duly executed as of November 29th, 2019.

BANK:

FROST BANK

By: _____
Name: Daniel Nash
Title: Relationship Manager

ATTEST:

_____
Name: Stephanie Ramon
Title: Administrative Officer

DEPOSITOR accepts and agrees as the 11/25/2019.

DEPOSITOR:

NUECES COUNTY HOSPITAL DISTRICT

By: _____
Name: Jonny F. Hipp, ScD, FACHE
Title: Administrator / Chief Executive Officer

ATTEST:

_____
Name: CARMINA H. MORENO
Title: Administrative Asst.

Frost Bank

SECURITY AGREEMENT

FROST BANK, (the "Bank"), for valuable consideration, the receipt and sufficiency of which is acknowledged, grants a security interest in and a pledge and assignment of (a) any and all Eligible Collateral (as defined below) from time to time held by The Federal Reserve Bank, Federal Home Loan Bank and/or The Bank of New York Mellon Trust Company, N.A. (the "Custodian"), identified on the Custodian's books as held for the account of the Depositor or jointly for the account of the Bank and the Depositor, together with (b) the products and proceeds of the foregoing and any substitutions or replacements thereof, whenever acquired and wherever located (the "Collateral") to **Nueces County Hospital District** (the "Depositor"), in order to secure the payment when due, of the Deposits (as defined below) pursuant to the depository agreement ("Depository Agreement") between the Bank and the Depositor, dated of even date with this security agreement (the "Agreement") :

1. **Definitions.** Except as otherwise expressly defined in this Agreement, all terms used herein which are defined in the Uniform Commercial Code as in effect from time to time in Texas (the "Code") have the same meaning as in the Code. All other terms capitalized but not defined herein or in the Code have the meanings assigned to them in the Depository Agreement.

"Account" shall mean the separate custodial account established with Custodian in the name of Bank and for the benefit and subject to the control of Depositor as secured party in accordance with this Agreement.

"Authorized Person" shall be any officer of Depositor or Bank, as the case may be, duly authorized to give Written Instructions on behalf of Depositor or Bank, respectively, such authorized persons for Depositor to be designated in a certificate substantially in the form of Exhibit B, attached hereto, as such exhibit may be amended from time to time, or as designated in such other forms as may be prescribed by the Bank.

"Book-Entry System" shall mean the Federal Reserve/Treasury Book Entry System for receiving and delivering U.S. Government Securities.

"Business Day" shall mean any day on which Custodian and Bank are open for business and on which the Book Entry System is open for business.

"Collateral Requirement" shall mean an amount of Securities with a Market Value equal to 102% of Uninsured Deposits; provided, however, to the extent that mortgage-backed securities (declining principal balance) are used as Eligible Collateral, "Collateral Requirement" shall mean an amount of Securities with a Market Value equal to 110% of Uninsured Deposits secured with such mortgage-backed securities.

"Deposits" shall mean all deposits by Depositor in Bank, including all accrued interest on such deposits, that are available for all uses generally permitted by Bank to Depositor for actually and finally collected funds under the Bank's account agreement or policies.

"Eligible Collateral" shall mean any Securities of the types enumerated in the Schedule of Eligible Collateral (which types are in compliance with the collateral policy adopted and approved by the

governing body of Depositor) attached hereto as Exhibit A, as such exhibit may be amended from time to time pursuant to a written amendment signed by each of the parties to this Agreement, and any Proceeds of such Securities.

"Market Value" shall mean: (i) with respect to any Security held in the Account, the market value of such Security as made available to Bank or Custodian by a generally recognized source selected by the Bank or the Custodian, plus, if not reflected in the market value, any accrued interest on such Security, or, if such source does not make available a market value, the market value shall be as determined by Custodian or the Bank in its sole discretion based on information furnished to Custodian or Bank by one or more brokers or dealers; and (ii) with respect to any cash held in the Account, the face amount of such cash.

"Proceeds" shall mean any principal or interest payments or other distributions made in connection with Eligible Collateral and anything acquired upon the sale, lease, license, exchange, or other disposition of Eligible Collateral.

"Security" or "Securities" shall include, without limitation, any security or securities held in the Book-Entry System; common stock and other equity securities; bonds, debentures and other debt securities; notes, mortgages, or other obligations; and any instruments representing rights to receive, purchase, or subscribe for the same, or representing any other rights or interests in such security or securities.

"Trust Receipt" shall mean evidence of receipt, identification, and recording, including a written or electronically transmitted advice or confirmation of transaction or statement of account. Each advice or confirmation of transaction shall identify the specific securities which are the subject of the transaction. If available, statements of account may be provided by the Bank or the Custodian at least once each month and when reasonably requested by the Depositor, and must identify all Eligible Collateral in the Account and its Market Value.

"Uninsured Deposits" shall mean that portion of the daily ledger balance (amount of funds plus the amount of any accrued interest on the funds) of Depositor's Deposits with Bank which exceeds the standard maximum deposit insurance amount ("SMDIA") of the Federal Deposit Insurance Corporation ("FDIC").

"Written Instructions" shall mean written communications actually received by Bank or Custodian from an Authorized Person or from a person reasonably believed by Bank or Custodian to be an Authorized Person by a computer, telex, telecopier, or any other system whereby the receiver of such communications is able to verify by codes or otherwise with a reasonable degree of certainty the identity of the sender of such communication.

2. <u>Security Requirement</u>.

(a) The Bank, to secure the timely payment of Uninsured Deposits made by Depositor, has deposited with Custodian certain Securities as more fully described in the initial confirmation or Trust Receipt of such deposit delivered by Custodian to Bank and Depositor respectively. Pursuant to the Code, the Custodian shall act as a bailee or agent of the Depositor and, to the extent not inconsistent with such duties, shall hold Securities as a securities intermediary (as such term is defined in Chapter 8 of the Code) in accordance with the provisions of this Agreement, the Depository Agreement, and of any agreement entered into with the Custodian further governing the provision of Security by the Bank for Uninsured Deposits.

(b) (i) To secure the timely payment of Uninsured Deposits made by Depositor with Bank, Bank agrees to deliver or cause to be delivered to Custodian for transfer to the Account, Eligible Collateral having a Market Value equal or greater than the Collateral Requirement.

(ii) If the Market Value of such Eligible Collateral on any Business Day is less than the Collateral Requirement for such day, the Bank shall be required to deliver additional Eligible Collateral having a Market Value equal to or greater than such deficiency as soon as possible but no later than the close of business of Custodian on the Business Day on which Bank determined such deficiency. If on any Business Day, the aggregate Market Value of the Eligible Collateral provided pursuant to this Agreement exceeds the Collateral Requirement for such day, Custodian shall, at the direction of Bank and with the approval of the Authorized Person acting on behalf of the Depositor, transfer from the Account to or for the benefit of Bank, Eligible Collateral having a Market Value no greater than such excess amount.

(iii) When additional Eligible Collateral is required to cover incremental Deposits, the Bank must receive the request for collateral one (1) Business Day prior to the Business Day the incremental Deposits are received, and the Bank shall be required to deliver additional Eligible Collateral having a Market Value equal to or greater than the deficiency on the Business Day the incremental Deposits are received.

(c) For any changes made to the Eligible Collateral held in the Account due to releases, substitutions, or additions of Eligible Collateral, the Custodian shall update its records of the Account accordingly as soon as possible and promptly issue a Trust Receipt to the Depositor and the Bank.

(d) The Bank shall be entitled to income on Securities held by the Custodian in the Account, and the Custodian may dispose of such income as directed by Bank without approval of the Depositor, to the extent such income is not needed to meet the Collateral Requirement.

3. **Custody of Securities.** The parties agree that all Securities held in the Account shall be treated as financial assets. For purposes of the Code, the security interest granted by Bank in the Eligible Collateral and Proceeds for the benefit of the Depositor is created, attaches, and is perfected for all purposes under Texas law from the time Custodian identifies the pledge of any Eligible Collateral or Proceeds to the Depositor and issues a Trust Receipt to the Depositor for such Eligible Collateral or Proceeds. The security interest of the Depositor in Securities and all Proceeds shall terminate upon the transfer of such Securities or Proceeds from the Account.

4. **Delivery of Securities.** Bank and Depositor agree that Securities and Proceeds delivered to or received by Custodian for deposit in the Account may be in the form of credits to the accounts of Custodian in the Book Entry System. Bank and Depositor authorize Custodian on a continuous and ongoing basis to deposit in the Book Entry System all Securities and Proceeds that may be deposited therein and to utilize the Book Entry System in connection with its performance under this Agreement. Securities and Proceeds credited to the Account and deposited in the Book Entry System will be represented in accounts that include only assets held by Custodian or its agent(s) for third parties, including but not limited to accounts in which assets are held in a fiduciary, agency, or representative capacity.

The Bank acknowledges that to the extent permitted by law, the records of the Bank and/or the Custodian with respect to the pledge of Eligible Collateral as described in this Agreement: (a) may be inspected by the Depositor or by the Texas Comptroller of Public Accounts (the "Comptroller"), at any time during regular business hours of the Bank or the Custodian; (b) such records may be subject to audit or inspection at any time pursuant to Sections 2257.025 and 2257.061 of the Texas Government Code, as amended; and (c) reports must be filed by the Custodian with the Comptroller when requested by the Comptroller.

5. **Collection of Securities.** If Depositor certifies in writing to Custodian that (a) Bank is in default under any underlying pledge or security agreement between Depositor and Bank, including the Depository Agreement and (b) Depositor has satisfied any notice or other requirement to which Depositor is subject pursuant to the Depository Agreement, then Depositor may give Custodian and any appointed receiver Written Instructions to transfer the value of specific amounts and issues of Securities held in the Account and, if applicable, specific amounts of the Proceeds held in the Account which have not previously been released to Bank, up to the amount that Depositor has in its depository account with Bank as of the date the Bank default occurs, to designated accounts of Depositor and to cease releasing to an account of Bank any Proceeds reflecting the interest and principal on Securities in the Account as provided in Section 2(d).

6. **Representation and Warranties.**

(a) Representations of Bank. Bank represents and warrants, which representations and warranties shall be deemed to be continuing, that:

(i) the Board of Directors of the Bank has authorized the Bank to enter into this Agreement, and such authorization is reflected in the approving resolution of the Bank's Board of Directors and in the minutes of the meeting of the Board of Directors at which this Agreement was approved, and this Agreement has been legally and validly entered into and is enforceable against Bank in accordance with its terms;

(ii) this Agreement and the pledge of Eligible Collateral under this Agreement do not violate or contravene the terms of the Bank's charter documents, by-laws, or any agreement or instrument binding on the Bank or its property, or any statute or regulation applicable to the Bank;

(iii) the Bank has entered into this Agreement, the Depository Agreement and the Third Party Custodian Agreement (A) in the ordinary course of business, (B) in good faith and on an arm's-length basis with the Depositor, (C) not in contemplation of bankruptcy or insolvency, and (D) without intent to hinder, delay, or defraud the Bank's creditors;

(iv) a copy of each of (A) this Agreement, (B) the Depository Agreement, (C) the Third Party Custodian Agreement the (D) resolution of the Board of Directors of the Bank approving this Agreement and the minutes of the meeting of the Board of Directors at which this Agreement was approved, have been placed (and will be continuously maintained) in the official records of the Bank;

(v) the Bank is sole legal and actual owner of the Securities or of beneficial interests in Securities deposited in the Account, free of all security interests or other encumbrances, except the security interest created by this Agreement;

(vi) this Agreement was executed by an officer of Bank who was authorized by the Bank's Board of Directors to do so;

(vii) the Bank is a bank or trust company duly authorized to do business in the State of Texas; and

(viii) all acts, conditions, and things required to exist, happen, or to be performed on its part precedent to and in the execution and delivery of this Agreement by it exist or have happened or have been performed.

(b) Representations of Depositor. Depositor represents and warrants, which representations and warranties shall be deemed to be continuing, that:

(i) this Agreement has been legally and validly entered into, has been approved by the Depositor's governing body, and does not and will not violate any statute or regulation applicable to it and is enforceable against Depositor in accordance with its terms;

(ii) the appointment of Custodian has been duly authorized by Depositor and this Agreement was executed by an officer of Depositor duly authorized to do so;

(iii) (A) all Securities identified on the Schedule of Eligible Collateral, attached hereto as Exhibit A, may be used to secure Depositor's Uninsured Deposits under applicable statutes and regulations, (B) the Collateral Requirement meets the requirements of such applicable statutes and regulations, (C) the governing board of Depositor has approved a collateral policy which authorizes all such Securities to be used as Eligible Collateral, and (D) such collateral policy complies with all applicable statutes and regulations;

(iv) it will not sell, transfer, assign, convey, pledge, or otherwise dispose in whole or in part its interests in or the rights with respect to any Securities deposited in the Account, or the Proceeds of such Securities, except as permitted in Section 5 of this Agreement;

(v) all acts, conditions, and things required to exist, happen, or to be performed on its part precedent to and in the execution and delivery of this Agreement exist or have happened or have been performed;

(vi) Depositor will comply with the terms of the Bank Depository Agreement and Third Party Custodian Agreement it has with the Bank in connection with this Agreement; and

(vii) In the event Depositor requests any financial services from the Bank other than depository services, the Depositor shall provide the Bank with a copy of the Depositor's current investment policy.

7. Continuing Agreement. This Agreement shall continue and remain in full force and effect and shall be binding upon the Bank and its successors until such time as (a) all Deposits have been paid in full to the Depositor or otherwise paid as instructed by the Depositor, and (b) the Depository Agreement is no longer in effect.

8. Rights and Remedies of the Depositor. The Depositor's rights and remedies with respect to the Collateral shall be those of a secured party under the Code and under any other applicable law, as the same may from time to time be in effect, in addition to those rights granted in this Agreement, in the Depository Agreement, and in any other agreement in effect between the Bank and the Depositor. The Depositor agrees to provide the Bank and the Custodian with reasonable notice of the sale, disposition, or other intended action subject to the provisions of this Agreement in connection with the Collateral, whether required by the Code or otherwise.

9. Application of Proceeds by the Depositor. In the event the Depositor requests that the Custodian and receiver sell or otherwise dispose of the Collateral in the course of exercising the remedies provided for in Section 5 above and in the Depository Agreement, any amounts held, realized, or received by the Depositor pursuant to the provisions of this Agreement, including the proceeds of the sale, in whole or in part, of any of the Collateral, shall be applied by the Depositor first toward the payment of any costs and expenses incurred by the Depositor (a) in enforcing this Agreement, (b) in realizing on selling, disposing or protecting any Collateral and (c) in enforcing or collecting any Deposits, including attorneys' fees, and then toward payment of the Deposits in such order or manner as the Depositor may elect. Any Collateral remaining after such application and after payment to the Depositor of all the Deposits in full shall be paid or delivered to the Bank, its successors or assigns, or as a court of competent jurisdiction may direct.

10. Notices. Any communication, notice, or demand to be given under this Agreement shall be duly given when delivered in writing or sent by telex or facsimile to a party at its address indicated below.

If to the Depositor, at:

Jonny F. Hipp, ScD, FACHE
Administrator/Chief Executive Officer
Nueces County Hospital District
555 N. Carancahua St., Suite #950
Corpus Christi, Texas 78401 - 0835
jonny.hipp@nchdcc.org

If to the Bank, at:

Eileen Slater; Senior Vice President
Frost Bank
111 W. Houston Street
San Antonio, Texas 78205
eileen.slater@frostbank.com

11. Miscellaneous.

(a) Updating Certificate of Authorized Persons. Depositor agrees to furnish to Bank a new and updated "Certificate of Authorized Persons" substantially in the form of Exhibit B, attached hereto, or in similar form as Bank may require, within a reasonable amount of time after there are additions or deletions to list of Authorized Persons authorized to act on behalf of the Depositor.

(b) Invalidity; Severability. If any clause or provision of this Agreement is for any reason

held to be invalid, illegal or unenforceable, such holding shall not affect the validity, legality or enforceability of the remaining clauses or provisions of this Agreement.

(c) Amendment. This Agreement may not be amended or modified in any manner except by written agreement executed by all of the parties.

(d) Assignment and Binding Effect. The Depositor may not assign all or any part of its rights or obligations under the Agreement without the Bank's prior express written consent, which may be withheld in the Bank's sole discretion. The Bank may not assign or delegate all or any part of its rights or obligations under the Agreement, including, without limitation, the performance of the services described herein without the DEPOSITOR'S prior express written consent, which may be withheld in DEPOSITOR'S sole discretion except in the event of a sale, purchase or acquisition of the Bank. The Agreement will be binding on and inure to the benefit of the successors and permitted assigns of either party.

(e) Governing Law; Venue. This Agreement shall be construed in accordance with the substantive laws of the State of Texas, without regard to conflicts of law principles thereof. Bank and Depositor hereby consent to the non-exclusive jurisdiction of a state or federal court situated in **Nueces** County, Texas, in connection with any dispute arising hereunder. Bank and Depositor hereby irrevocably waive, to the fullest extent permitted by applicable law, any objection which it may now or hereafter have to the laying of venue of any such proceeding brought in such a court and any claim that such proceeding brought in such a court has been brought in an inconvenient forum. Bank and Depositor each hereby irrevocably waives any and all rights to trial by jury in any legal proceeding arising out of or relating to this Agreement.

(f) Liability of the Parties. The Bank's and Depositor's duties and responsibilities to each other are limited as set forth in this Agreement, except with respect to any provisions of the law which cannot be varied or waived by agreement. **TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, NEITHER BANK NOR DEPOSITOR WILL BE LIABLE FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY, SPECIAL, OR PUNITIVE DAMAGES (INCLUDING WITHOUT LIMITATION, LOSS OF REVENUE OR ANTICIPATED PROFITS) OR FOR ANY INDIRECT LOSS THAT THE OTHER PARTY MAY INCUR OR SUFFER IN CONNECTION WITH THE SERVICES PROVIDED HEREUNDER (EVEN IF SUCH PARTY HAS BEEN INFORMED OF THE POSSIBILITY OF SUCH DAMAGES), INCLUDING WITHOUT LIMITATION, ATTORNEYS' FEES.**

IN WITNESS WHEREOF, the Bank and Depositor have caused this Agreement to be duly executed as of November 29th, 2019.

FROST BANK

By _____
Name: Daniel Nash
Title: Relationship Manager

DEPOSITOR ACCEPTS AND AGREES
as of 11/25/2019

NUECES COUNTY HOSPITAL DISTRICT

By _____
Name: Jonny F. Hipp, ScD, FACHE
Title: Administrator / Chief Executive Officer

EXHIBIT A
Schedule of Eligible Collateral

Eligible Collateral

All funds on deposit under the provisions of this agreement shall be continuously secured in accordance with the Texas Public Funds Collateral Act, Chapter 2257 of the Texas Government Code.

The following securities are approved as collateral for **Nueces County Hospital District** funds:

1. United States Treasury Notes, Bills, Bonds or obligations fully and unconditionally guaranteed as to principal and interest by the full faith and credit of the United States.

2. Obligations of the Federal Home Loan Bank, Federal Home Loan Mortgage Corporation, or the Federal National Mortgage Association.

3. Obligations of the Government National Mortgage Association.

4. Any obligation of an approved government agency which is considered to be an asset-backed, mortgage-backed, or pooled security.

5. Direct obligations of this State or its agencies or instrumentalities with an "A" or better rating..

EXHIBIT B
CERTIFICATE OF AUTHORIZED PERSONS
(Depositor)

The undersigned hereby certifies that he/she is the duly elected and acting **Secretary** of **Nueces County Hospital District** (the "Depositor"), and further certifies that the following officers or employees of Depositor have been duly authorized in conformity with the approval of the Depositor's governing body to deliver Written Instructions to **The Federal Reserve Bank, Federal Home Loan Bank and/or The Bank of New York Mellon Trust Company, N.A.** ("Custodian") pursuant to the Security Agreement between Depositor and the Bank dated **December 1 2019**, and that the signatures appearing opposite their names are true and correct:

Jonny F. Hipp Name	Administrator/CEO Title	Jonny F Hipp Signature
Belinda E. Chism Name	Assistant Administrator Title	Belinda E Chism Signature
Name	Title	Signature
Name	Title	Signature
Name	Title	Signature
Name	Title	Signature
Name	Title	Signature

This certificate supersedes any certificate of authorized individuals you may currently have on file.

Signed: Jonny F Hipp
Jonny F. Hipp, SED, FACHE
Title: Administrator / CEO / Secretary
Date: 11/25/2019

THIRD PARTY CUSTODIAN AGREEMENT
(Collateralized Municipal Deposits)

THIS AGREEMENT, made and executed as of December 1, 2019 by and among the Nueces County Hospital District (the "Public Entity"), Frost Bank (the "Bank") and The Bank of New York Mellon Trust Company, N.A. (the "Custodian").

WITNESSETH

WHEREAS, Public Entity desires to maintain or continue to maintain public deposits with Bank;

WHEREAS, Bank desires to obtain such deposits and to provide security therefor as required by applicable law, regulation or rule;

WHEREAS, Custodian agrees to provide safekeeping services and to hold any securities pledged by Bank in a custodial account established for the benefit of Public Entity as secured party pursuant to this Agreement;

NOW, THEREFORE, in consideration of the mutual promises set forth hereafter, the parties hereto agree as follows:

1. Security Requirements

(a) Bank, to secure the timely payment of Uninsured Deposits heretofore or hereafter made by Public Entity, including any interest due thereon and any costs or expenses incurred by Public Entity and arising out of the collection of any deposits made with Bank, has deposited with Custodian certain investment property as identified by the parties on Schedule A, attached hereto, and as more fully described in the initial confirmation Trust Receipt of such deposit delivered by Custodian to Bank and Public Entity respectively (which investment property together with any additions thereto, substitutions therefor and the proceeds thereof, are hereinafter collectively referred to as "Collateral"), to be held by Custodian pursuant to the provisions hereof. Pursuant to the Texas Business and Commerce Code, as amended, Custodian shall act as a bailee or agent of Public Entity and, to the extent not inconsistent therewith, hold the Collateral as a securities intermediary (as such terms are defined in Chapter 8 of the Texas Business & Commerce Code, as amended, and in Chapter 2257 of the Texas Government Code, as amended) and in accordance with the provisions hereof. Bank hereby grants to Public Entity a pledge and security interest in and to such Collateral and shall deliver Collateral to Custodian in the manner prescribed in Section 2 of this Agreement.

(b) Subject to paragraph (c) below, Public Entity authorizes Custodian as its agent to approve substitutions of Collateral ("Substitute Collateral") supplied to Custodian by Bank for Collateral in the Account upon receipt of Written Instructions from Bank identifying the Collateral to be substituted. Such Written Instructions shall when received by Custodian be deemed Bank's representation and warranty, on which Custodian may rely without further inquiry, that (i) the Substitute Collateral constitutes Collateral that is eligible for deposit hereunder and (ii) has a Margin Value equal to or greater than the Margin Value of the Collateral to be substituted (each, an "Approved Substitution"). Following completion of each Approved Substitution Custodian shall update its records of the Account as soon as possible and issue a Trust Receipt to Public Entity in accordance with the requirements of paragraph (f) below.

(c) Custodian assumes no responsibility to determine or monitor whether or not any Collateral originally deposited hereunder or Substitute Collateral or additional Collateral hereafter deposited are eligible for deposit under applicable law, rule or regulation or whether the Market Value of the Collateral thereof meets the requirements of any law, rule or regulation applicable to the deposit hereunder. The determination of eligibility and whether the Market Value of the Collateral satisfies statutory or regulatory requirements will be the responsibility of Bank. Custodian shall be fully protected in relying on Written Instructions of either Bank or Public Entity directing Custodian to release any of the Collateral to Bank. To the extent of any conflict in the instructions of Public Entity

and Bank, the instructions of Public Entity shall control and Bank shall hold Custodian harmless for acting in accordance with Public Entity's instructions.

(d) Custodian shall promptly issue a Trust Receipt to Public Entity on any Business Day on which Collateral is transferred to and from the Account. For the avoidance of doubt, it is understood and agreed that Trust Receipts may be combined to identify more than one transaction on any one Business Day and Custodian shall not be required to issue more than one Trust Receipt to Public Entity on any Business Day.

2. Custody of Collateral

(a) Bank and Public Entity hereby appoint Custodian as custodian of all Collateral at any time delivered to Custodian pursuant to this Agreement. Custodian hereby accepts appointment as such Custodian and agrees to establish and maintain the Account and appropriate records identifying the Collateral as pledged by Bank to Public Entity. Collateral in the Account shall be kept separate and apart from the general assets of Custodian on Custodian's books and records. Subject to the terms hereof, Custodian, in performing its duties and responsibilities pursuant to this Agreement, shall act as custodian for, and agent of, Public Entity. The parties agree that all securities held in the Account shall be treated as financial assets. For purposes of the Texas Business and Commerce Code, as amended, the security interest granted by Bank in the Collateral for the benefit of Public Entity is created, attaches, and is perfected for all purposes under Texas law from the time Custodian receives Collateral for deposit or credit to the Account and issues a Trust Receipt to Public Entity for such Collateral. The security interest of Public Entity in the Collateral and all Proceeds thereof shall terminate upon the transfer of such Collateral or Proceeds from the Account.

(b) The Bank and Public Entity agree that Collateral delivered to the Custodian for deposit in or credit to the Account may be in the form of credits to the accounts of Custodian at the Book-Entry System or a Depository or by delivery to the Custodian of physical certificates in a form suitable for transfer or with an assignment in blank to the Public Entity or Custodian. The Bank and Public Entity hereby authorize the Custodian on a continuous and ongoing basis to deposit in the Book-Entry System and/or the Depositories all Collateral that may be deposited therein and to utilize the Book-Entry System and/or Depositories and the receipt and delivery of physical securities or any combination thereof in connection with its performance hereunder. Collateral that is not held in the Book-Entry System, Depositories or through another financial intermediary will be held in the Custodian's vault and physically segregated from securities and other non-cash property belonging to the Custodian.

(c)(i) Upon the initial and each subsequent deposit of Collateral and Proceeds into the Account (including but not limited to any deposit of Collateral as part of an Approved Substitution), Custodian shall promptly provide Public Entity with a Trust Receipt. Additional customized Account statements may be available upon mutual agreement of Public Entity and Custodian.

(ii) Public Entity agrees that it shall promptly review all Trust Receipts and Account statements delivered to it by Custodian and shall promptly advise Custodian and Bank by Written Instruction of any error, omission or inaccuracy in such statements. In the event that Custodian receives such a Written Instruction identifying a specific concern with respect to a suspected error, failure or omission with respect to the Account, Custodian shall undertake to correct any errors, failures or omissions, provided that Custodian and Bank shall work together to determine that such error, failure or omission actually occurred and Custodian shall notify Public Entity of its action concerning each such error, failure, or omission.

(d) The Account shall not be subject to any security interest, lien or any right of set-off by Custodian.

(e) With respect to all Collateral held in the Account, Custodian by itself, or through the use of the Book-Entry System or the appropriate Depository, shall, unless otherwise instructed to the contrary by Bank: (i) collect all income and other payments reflecting interest and principal on the Collateral in the Account and credit such amounts to the account of Bank; (ii) forward to Bank copies of all information or documents that it may receive from an issuer of Collateral which, in the opinion of Custodian, is intended for the beneficial owner of the Collateral including, without limitation all proxies and other authorizations properly executed and all proxy statements, notices and reports; (iii) execute, as Custodian, any certificates of ownership, affidavits, declarations or other certificates under any tax laws now or hereafter in effect in connection with the collection of bond and note coupons; (iv) hold directly, or through the Book-Entry System or Depository, all rights issued with respect to any Collateral held by

Custodian hereunder; and (v) upon receipt of Written Instructions from Bank, Custodian will exchange Collateral held hereunder for other securities and/or cash in connection with (A) any conversion privilege, reorganization, recapitalization, redemption in kind, consolidation, tender offer or exchange offer, or (B) any exercise, subscription, purchase or other similar rights.

(f) Custodian agrees to file reports with the Comptroller of Public Accounts of the State of Texas (the "Comptroller") regarding the Collateral pledged to secure the Uninsured Deposits of Public Entity hereunder, as and when required by the Comptroller.

3. Events of Default

Subject to applicable law, rules and regulations, or regulatory authority and oversight, in the event Bank shall fail to pay Public Entity any amount of the Uninsured Deposits by Public Entity covered by this Agreement in accordance with the terms of such Deposit, or should Bank fail or suspend active operations, the Uninsured Deposits in such Bank shall become due and payable immediately and Public Entity shall have the right to unilaterally demand delivery of all the Collateral in the Account by Written Instructions to Custodian and to sell such securities at public or private sale. In the event of such sale, Public Entity, after deducting all legal expenses and other costs, including reasonable attorneys' fees, from the proceeds of such sale, shall apply the remainder towards any one or more of the liabilities of Bank to Public Entity and shall return the surplus, if any, to Bank.

4. Representation and Warranties

(a) Representations of Bank. Bank represents and warrants, which representations and warranties shall be deemed to be continuing, that:

(i) this Agreement has been legally and validly entered into, does not and will not violate any statute or regulation applicable to it and is enforceable against Bank in accordance with its terms;

(ii) it is the legal and actual owner, free and clear of all liens and claims, of all the Collateral pledged pursuant to this Agreement;

(iii) this Agreement was executed by an officer of Bank who was authorized by Bank's board of directors to do so and will at all times be maintained as an official record of Bank;

(iv) all Collateral held by Custodian hereunder are eligible to secure Public Entity's deposits at Bank under applicable statutes or regulations and the Market Value of the Collateral held by Custodian hereunder at all times meet the requirements of such statutes or regulations;

(v) Bank is a bank or trust company duly authorized to do business in the state where it is located;

(vi) all acts, conditions and things required to exist, happen or to be performed on its part precedent to and in the execution and delivery of this Agreement exist or have happened or have been performed.

(b) Representations of Public Entity. Public Entity hereby represents and warrants, which representations and warranties shall be deemed to be continuing, that:

(i) this Agreement has been legally and validly entered into, does not and will not violate any statute or regulation applicable to it and is enforceable against Public Entity in accordance with its terms;

(ii) the appointment of Custodian has been duly authorized by Public Entity and this Agreement was executed by an officer of Public Entity duly authorized to do so;

(iii) it will not transfer, assign its interests in or the rights with respect to any Collateral pledged pursuant to this Agreement, except as authorized pursuant to Section 3 of the Agreement;

(iv) all acts, conditions and things required to exist, happen or to be performed on its part precedent to and in the execution and delivery of this Agreement exist or have happened or have been performed.

5. Concerning Custodian

(a) Custodian shall not be liable for any loss or damage, including counsel fees, resulting from its action or omission to act or otherwise, except for any loss or damage arising out of its own negligence or willful misconduct, and shall have no obligation hereunder for any loss or damage, including counsel fees, which are sustained or incurred by reason of any action or inaction by the Book-Entry System or any Depository. In no event shall Custodian be liable to Public Entity, Bank or any third party for special, indirect or consequential damages, or lost profits or loss of business, arising in connection with this Agreement. Custodian may, with respect to questions of law, apply for and obtain the advice and opinion of counsel and shall be fully protected with respect to anything done or omitted by it in good faith and conformity with such advice or opinion. Public Entity, to the extent permitted by law, and Bank agree, jointly and severally, to indemnify Custodian and to hold it harmless against any and all costs, expenses, damages, liabilities or claims, including reasonable fees and expenses of counsel, which Custodian may sustain or incur or which may be asserted against Custodian by reason of or as a result of any action taken or omitted by Custodian in connection with operating under this Agreement, except those costs, expenses, damages, liabilities or claims arising out of the negligence or willful misconduct of Custodian or any of its employees or duly appointed agents. This indemnity shall be a continuing obligation of Public Entity and Bank notwithstanding the termination of this Agreement.

(b) Custodian shall not be responsible for, or considered to be custodian of, any Collateral received by it for deposit in the Account until Custodian actually receives and collects such Collateral directly or by the final crediting of Custodian's account on the books of the Book-Entry System or the appropriate Depository. Custodian will be entitled to reverse any credits made on Public Entity's behalf where such credits have been previously made and the Collateral are not finally collected.

(c) Custodian shall have no duties or responsibilities whatsoever except such duties and responsibilities as are specifically set forth in this Agreement and no covenant or obligation shall be implied against Custodian in connection with this Agreement.

(d) Public Entity's and Bank's authorized officers and, if permitted by law, representatives of the Comptroller, upon reasonable notice, shall each have access to Custodian's books and records maintained with respect to Public Entity's and Bank's respective interests in the Account during Custodian's normal business hours. Upon the reasonable request of Public Entity, Bank or the Comptroller when applicable law permits, copies of any such books and records shall be provided by Custodian to the requesting party's authorized officer at the requesting party's expense.

(e) In performing hereunder, Custodian may enter into subcontracts, agreements and understandings with third parties (including affiliates) whenever and on such terms and conditions as it deems necessary or appropriate. If any of such subcontracts, agreements, or understandings with third parties are for the deposit of Collateral for the benefit of Public Entity, (i) such third party will qualify as a "permitted institution" pursuant to Chapter 2257 of the Texas Government Code (the "Texas Public Funds Collateral Act"), (ii) Custodian shall cause such third party to provide records to Custodian evidencing the deposit of Collateral with such third party, and (iii) records of the third party relating to such Collateral will at all times state the name of Custodian. No such subcontract, agreement or understanding shall discharge Custodian from its obligations hereunder.

(f) Reliance on Pricing Services. If Custodian, as an accommodation to Bank or the Public Entity, agrees to provide information concerning Market Values, Custodian is authorized to utilize any generally recognized pricing information service (including brokers and dealers of securities) in order to provide Market Values hereunder, and Bank and Public Entity agree that Custodian shall not be liable for any loss, damage, expense,

liability or claim (including attorneys' fees) incurred as a result of errors or omissions of any such pricing information service, broker or dealer.

(g) Force Majeure. Custodian shall not be responsible or liable for any failure or delay in the performance of its obligations under this Agreement arising out of or caused, directly or indirectly, by circumstances beyond its reasonable control, including without limitation, acts of God, earthquakes, fires, floods, wars, civil or military disturbances, sabotage, epidemics, riots, loss or malfunctions of utilities, computer (hardware or software) or communications service, labor disputes, acts of civil or military authority, or governmental, judicial or regulatory action; provided however, that Custodian shall use its best efforts to resume normal performance as soon as practicable under the circumstances. Provided, however, that if Custodian cannot resume normal performance within thirty (30) days of the cessation of such "force majeure" event, in addition to the termination rights set forth in Section 6 of this Agreement, Bank and Public Entity may terminate this Agreement immediately and without early termination penalty, liquidated damages or other penalty.

6. Termination

Any of the parties hereto may terminate this Agreement by giving to the other parties a notice in writing specifying the date of such termination, which shall be the earlier of (i) not less than 90 days after the date of giving such notice or (ii) the date on which the Deposits are repaid in full. Such notice shall not affect or terminate Public Entity's security interest in the Collateral in the Account. Upon termination hereof, Custodian shall follow such reasonable Written Instructions of Bank and Public Entity concerning the transfer of custody of Collateral, collateral records and other items. Upon the date set forth in the termination notice, this Agreement shall terminate except as otherwise provided herein and all obligations of the parties to each other hereunder shall cease.

7. Miscellaneous

(a) Public Entity and Bank each agree to furnish to Custodian a new Certificate substantially in the form of Exhibit A and Exhibit B, respectively, attached hereto in the event that any present Authorized Person ceases to be an Authorized Person or in the event that any other Authorized Persons are appointed and authorized. Until such new Certificate is received, Custodian shall be fully protected in acting upon Written Instructions or signatures of the present Authorized Persons.

(b) Custodian shall be entitled to rely upon any Certificate or Written Instruction actually received by Custodian and reasonably believed by Custodian to be duly authorized and delivered. Notwithstanding anything herein to the contrary, it is understood and agreed that regardless of the circumstances, Custodian shall accept and solely act upon Written Instructions.

(c) Any Written Instructions or other instrument in writing authorized or required by this Agreement shall be given to Custodian and shall be sufficiently given if sent to Custodian by regular mail to its offices at

c/o The Bank of New York Mellon
101 Barclay Street, 4th Floor
New York, NY 10286
Attention: GCS – Collateral Management

or at such other place as Custodian may from time to time designate in writing.

(d) Any notice or other instrument in writing authorized or required by this Agreement to be given to Bank shall be sufficiently given if sent to Bank by regular mail to its offices at

Eileen Slater
Frost Bank, Capital Markets
111 W. Houston
San Antonio, Texas 78205
E-mail: Eileen.Slater@FrostBank.com

or at such other place as Bank may from time to time designate in writing.

(e) Any notice or other instrument in writing, authorized or required by this Agreement to be given to Public Entity shall be sufficiently given if sent to Public Entity by regular mail to its offices at

Jonny F. Hipp, ScD, FACHE; Administrator / Chief Executive Officer
Nueces County Hospital District
555 North Carancahua, Suite #950
Corpus Christi, Texas 78401 - 0835
E-Mail: Jonny.Hipp@nchdcc.org

or at such other offices as Public Entity may from time to time designate in writing.

(f) In case any provision in or obligation under this Agreement shall be invalid, illegal or unenforceable in any jurisdiction, the validity, legality and unenforceability of the remaining provisions or obligations shall not in any way be affected or impaired thereby and if any provision is inapplicable to any person or circumstances, it shall nevertheless remain applicable to all other persons and circumstances.

(g) This Agreement may not be amended or modified in any manner except by written agreement executed by all of the parties hereto.

(h) This Agreement shall extend to and be binding upon the parties hereto, and their respective successors and assigns; provided however, that this Agreement shall not be assignable by any party without the written consent of the other parties.

(i) This Agreement shall be construed in accordance with the substantive laws of the State of Texas, without regard to conflicts of laws principles thereof. In connection with any dispute arising hereunder, Bank, Public Entity and Custodian hereby consent to the non-exclusive jurisdiction of a state or federal court situated in the county in the State of Texas in which Public Entity maintains its principal office. Bank, Public Entity and Custodian hereby irrevocably waive, to the fullest extent permitted by applicable law, any objection which it may now or hereafter have to the laying of venue of any such proceeding brought in such a court and any claim that such proceeding brought in such a court has been brought in an inconvenient forum. Bank, Public Entity and Custodian each hereby irrevocably waives any and all rights to trial by jury in any legal proceeding arising out of or relating to this Agreement.

8. Adjudication of Claims. Solely to the extent required or permitted under applicable law governing the operations of the Public Entity (including Tex. Civ. Prac. & Rem Code Ann. §101.001 et. seq. (the Texas Tort Claims Act) and Tex. Loc. Gov't Code Ann. §271.151 et. seq. (Adjudication of Claims Arising Under Written Contacts with Local Governmental Entities)), each party hereto irrevocably agrees not to claim or assert, for itself or its assets, immunity (sovereign or otherwise) from suit, execution, attachment (before or after judgment) or any other legal process arising out of this Agreement in respect of such party's obligations hereunder.

9. Compliance with Texas Government Code Section 2270.002. As required by Section 2270.002 of the Texas Government Code, Custodian hereby verifies that it does not boycott Israel and will not boycott Israel during the term of this Agreement. For purposes of this Agreement, the phrase "boycott Israel" means refusing to deal with, terminating business activities with, or otherwise taking any action that is intended to penalize, inflict economic harm on, or limit commercial relations specifically with Israel or in an Israeli-controlled territory, but does not include an action made for ordinary business purposes.

10. Compliance with Texas Government Code Section 2252.152. Pursuant to Section 2252.152 of the Texas Government Code, Custodian hereby verifies that it is not engaged in active business operations with Sudan, Iran or a foreign terrorist organization. For purposes of this Agreement, the phrase "foreign terrorist organization" means an organization designated as a foreign terrorist organization by the United States secretary of state as authorized by 8 U.S.C. Section 1189.

11. Definitions

Whenever used in this Agreement, the following terms shall have the following meanings:

(a) "Account" shall mean the custodial account established with Custodian for the benefit of Public Entity as secured party in accordance with this Agreement.

(b) "Authorized Person" shall be any officer of Public Entity or Bank, as the case may be, duly authorized to give Oral Instructions or Written Instructions on behalf of Public Entity or Bank, such persons to be designated in a Certificate substantially in the form of Exhibit "A" for Public Entity or Exhibit "B" for Bank attached hereto as such exhibits may be amended from time to time.

(c) "Approved Substitution" shall have the meaning set forth in paragraph (e) of Section 1of this Agreement.

(d) "Book-Entry System" shall mean the Federal Reserve/Treasury Book-Entry System for receiving and delivering U.S. Government securities.

(e) "Business Day" shall mean any day on which Custodian and Bank are open for Business and on which the Book-Entry System and/or the Depositories are open for business.

(f) "Certificate" shall mean the Certificate of Authorized Persons attached hereto as Exhibit "A" or Exhibit "B".

(g) "Comptroller" shall have the meaning set forth in paragraph (d) of Section 5 of this Agreement.

(g) "Depository" shall include the Depository Trust Company and any other securities depository and clearing agency (and their successors and nominees) registered with the Securities and Exchange Commission or otherwise regulated by appropriate federal or state agencies as a securities depository or clearing agency.

(h) "Deposits" shall mean all deposits by Public Entity in Bank that are available for all uses generally permitted by Bank to Public Entity for actually and finally collected funds under Bank's account agreement or policies.

(i) "Market Value" shall mean, with respect to any Security held in the Account, the market value of such Security as made available to Custodian by a generally recognized source selected by Custodian plus, if not reflected in the market value, any accrued interest thereon, or, if such source does not make available a market value, the market value shall be as determined by Custodian in its sole discretion based on information furnished to Custodian by one or more brokers or dealers; provided however that, if agreed in writing by the parties hereto, Bank may provide Custodian with such Market Values.

(j) "Nationally Recognized Statistical Rating Organization" shall mean Moody's, Standard and Poor's, Fitch, Duff and Phelps, BankWatch and IBCA.

(k) "Public Entity" shall mean a state or a political or governmental entity, agency, instrumentality, or subdivision of the State of Texas, including a municipality, an institution of higher education, as defined by Section 61.003, Texas Education Code, a junior college, a district created under Article XVI, Section 59, of the Texas Constitution, and a public hospital.

(l) "Substitute Collateral" shall have the meaning set forth in paragraph b of Section 1 of this Agreement.

(m) "Trust Receipt" shall mean evidence of receipt, identification, and recording, including a written or electronically transmitted advice or confirmation of transaction or statement of account. Each advice or confirmation of transaction shall identify the Collateral which is the subject of the transaction and state the Market Value thereof.

Statements of account shall identify all Collateral in the Account, the Aggregate Margin Value thereof, and the applicable Collateral Requirement.

(n) "Uninsured Deposits" shall mean that portion of Public Entity's Deposits with Bank which exceeds the insurance coverage available from the Federal Deposit Insurance Corporation.

(o) "Written Instruction(s)" shall mean written communications actually received by Custodian from an Authorized Person or from a person reasonably believed by Custodian to be an Authorized Person by a computer, telex, telecopier or any other system whereby the receiver of such communications is able to verify by codes or otherwise with a reasonable degree of certainty the identity of the sender of such communication.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their respective officers thereunto duly authorized and their respective seals to be hereunto affixed, as of the day and year first above written.

NUECES COUNTY HOSPITAL DISTRICT

Jonny F. Hipp

By: Jonny F. Hipp, ScD, FACHE

Title: Administrator / Chief Executive Officer

FROST BANK

Donna J Cole

By: Daniel Nash Donna J Cole

Title: Relationship Manager Assistant Vice President PF Treasury Mgmt

THE BANK OF NEW YORK MELLON TRUST COMPANY, N.A.

DocuSigned by:
David DiNardo
754123712B9A417...

By: David DiNardo

Title: Managing Director

EXHIBIT A
CERTIFICATE OF AUTHORIZED PERSONS
(Public Entity - Written Instructions)

The undersigned hereby certifies that he/she is the duly elected and acting Secretary of the Nueces County Hospital District (the "Public Entity"), and further certifies that the following officers or employees of Public Entity have been duly authorized in conformity with Public Entity's Board of Managers to deliver Written Instructions to The Bank of New York Mellon Trust Company, N.A. ("Custodian") pursuant to the Third Party Custodian Agreement between Public Entity, Frost Bank ("Bank") and Custodian dated December 1, 2019, and that the signatures appearing opposite their names are true and correct:

Name	Title	Signature
Jonny E. Hipp	Administrator / CEO	
Belinda E. Chism	Assistant Administrator	

This certificate supersedes any certificate of authorized individuals you may currently have on file.

Name: John B. Martinez

Title: Chairman, NCHD Board of Managers

Date: November 25, 2019

Schedule A
SCHEDULE OF ELIGIBLE COLLATERAL

Third Party Custodian Agreement (Collateralized Municipal Deposits) dated as of December 1, 2019, among Nueces County Hospital District (NU50) ("Local Gov't"), Frost Bank ("Bank") and The Bank of New York Mellon Trust Company N.A. ("Custodian").

	Yes/No	Margin
U.S. TREASURIES		
BILLS	Y	102%
BONDS	Y	102%
NOTES	Y	102%
STRIPS	Y	102%
SYNTHETIC TREASURIES	N	
(e.g.CATS,COUORS,TIORS)		
AGENCY DEBENTURES		
FAMC (Fed Agriculture Mtge Corp)	Y	102%
FCFAC (Farm Credit Finan. Asst.)	Y	102%
FFCB (Farm Credit System Banks)	Y	102%
FmHA (Farmers Home Admin.)	Y	102%
FHLB (Federal Home Loan Banks)	Y	102%
FHLMC (Federal Home Loan Mtge)	Y	102%
FICO (Financing Corporation)	Y	102%
FLBB (Federal Land Bank Bonds)	N	
FNMA (Federal Nat'l Mtge Corp)	Y	102%
REFCO (Resolution Funding Corp)	N	
SLMA (Student Loan Mtge Corp)	N	
TVA (Tennessee Valley Authority)	Y	102%
USPS (U.S. States Postal Service)	N	
AGENCY STRUCTURED NOTES	N	
INTERNATIONAL AGENCIES		
ADBB (Asian Development Bank)	N	
AFDB (African Development Bank)	N	
IADB (Inter-American Dev. Bank)	N	
IFCO (International Finance Corp)	N	
WLDB (World Bank)	N	

	Yes/No	Margin
GNMA		
TRUST RECEIPTS	N	
GNMA I/II-SINGLE FAMILY	Y	102%
GNMA I/II-OTHERS-FIXED RATE	Y	102%
GNMA I/II OTHERS-ADJUST. RATE	Y	102%
AGENCY MORTGAGE BACKS		
TRUST RECEIPTS	N	
PASS THROUGHS-FIXED RATE	Y	102%
PASS THROUGHS-ADJUST. RATE	Y	102%
MBS STRIPS (IO,PO,RECOMB)	N	
AGENCY REMICS/CMOS		
REMIC TYPES:		
RESIDUALS	N	
INVERSE IO FLOATERS	N	
IOETTES	N	
INTEREST ONLY (IO)	N	
PRINCIPAL ONLY (PO)	N	
INVERSE FLOATERS	N	
SUPER FLOATERS	N	
COMPANION FLOATERS	N	
SEQUENTIAL AND OTHER FLOATERS	Y	102%
PAC & OTHER SCHEDULED FLOATERS	Y	102%
Z BONDS	N	
COMPANION BONDS	N	
SEQUENTIAL BONDS	Y	102%
TAC BONDS	Y	102%
PAC & OTHER SCHEDULED BONDS	Y	102%
MUNICIPAL BOND		
MUNICIPAL BONDS (≥ A)	Y	102%
MUNICIPAL BONDS (≤ BB+,Ba1,BB+)	N	

PRIVATE LABELS CMOS	Yes/No	Margin
≥BBB-,Baa3,BBB-	N	
≤ BB+,Ba1,BB+	N	
CMO TYPES:		
RESIDUALS	N	
INVERSE IO FLOATERS	N	
IOETTES	N	
INTEREST ONLY (IO)	N	
PRINCIPAL ONLY (PO)	N	
INVERSE FLOATERS	N	
SUPER FLOATERS	N	
COMPANION FLOATERS	N	
SEQUENTIAL AND OTHER FLOATERS	N	
PAC & OTHER SCHEDULED FLOATERS	N	
Z BONDS	N	
COMPANION BONDS	N	
SEQUENTIAL BONDS	N	
TAC BONDS	N	
PAC & OTHER SCHEDULED BONDS	N	
ASSET BACKED SECURITIES		
ASSET BACKED SECURITIES (≥BBB-,Baa3,BBB-)	N	
ASSET BACKED SECURITIES (≤ BB+,Ba1,BB+)	N	
CORPORATES		
CORPORATE BOND (≥BBB-,Baa3,BBB-)	N	
CORPORATE BOND (≤ BB+,Ba1,BB+)	N	
MEDIUM-TERM NOTE (≥BBB-,Baa3,BBB-)	N	
MEDIUM-TERM NOTE (≤ BB+,Ba1,BB+)	N	
MONEY MARKETS		
COMMERCIAL PAPER (≥A1/P1/F1)	N	
COMMERCIAL PAPER (≤A2/P2/F2)	N	
BANKERS ACCEPTANCE	N	
CD (DOMESTIC & EURO)	N	
BANK NOTES	N	

BUYER ACKNOWLEDGES AND AGREES THAT IF A CLASS OF SECURITY CONTAINS NEW ISSUES OF SECURITIES, SUCH NEW ISSUES OF SECURITIES SHALL BE DEEMED TO BE ELIGIBLE COLLATERAL.

[LOCAL GOVERNMENT]
NUECES COUNTY HOSPITAL DISTRICT
Jonny F. Hipp
By: Jonny F. Hipp, Sed. FACHE
Title: Administrator / Chief Executive Officer
Date: 11/25/2019

[BANK]
FROST BANK
Donna Cole
By: Donna Cole
Title: Assistant Vice President
Date:

ACCEPTED:
THE BANK OF NEW YORK MELLON TRUST COMPANY N.A.
DocuSigned by: David DiNardo
By: 75412371289A417...
Title: David DiNardo
Date: Managing Director

3 I.

CAROLYN VAUGHN
Commissioner
Precinct 1

JOE A. GONZALEZ
Commissioner
Precinct 2

County of Nueces

JOHN MAREZ
Commissioner
Precinct 3

BRENT CHESNEY
Commissioner
Precinct 4

BARBARA CANALES
County Judge
Nueces County Courthouse, Room 303
901 Leopard Street
Corpus Christi, Texas 78401-3697

AGREEMENT AMENDMENT NO. 3

WHEREAS, the County of Nueces (**"Client"**), Nueces County Hospital District ("Hospital District") and Wellpath LLC, entered into an agreement with the effective date of December 1, 2015, and Amendment No. 1 to the Agreement on August 22, 2018, and Amendment No. 2 to the Agreement on March 27, 2019 for Medical Services for Inmates at Jail Facilities and Residents at the Juvenile Center (RFP No. 2993-15).

WHEREAS, the parties now want to exercise the option as set out in Article 7.1 of the Agreement to extend the term of the Agreement for one (1) year, this being the final renewal year;

WHEREAS, according to the Agreement, Article 8, Compensation, optional year 5 term compensation rate will be $3,504,484.00.

NOW, THEREFORE, Nueces County, Hospital District and Wellpath LLC, in consideration of the mutual agreements contained in the original Agreement and additional time provided pursuant to this agreement do hereby mutually agree:

1. To exercise the renewal option of one (1) year as set out in Article 7.1 of the Agreement extending the termination date of the Agreement to November 30, 2020.

2. All other provisions of Agreement shall remain the same.

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound, have duly executed this Amendment in triplicate.

WITNESS our hands on this 4th day of December, 2019.

NUECES COUNTY

Barbara Canales
Nueces County Judge

COMMISSIONERS COURT NUECES COUNTY

NUECES COUNTY HOSPITAL DISTRICT

Jonny F. Hipp
Administrator/Chief Executive Officer

ATTEST:

KARA SANDS, County Clerk

WELLPATH LLC

Print Name: JORGE DOMINICIS
Title: CEO

20190509-12/4

Email to Krista.Champine@nuecesco.com

PLEASE SIGN, DATE AND RETURN - THANK YOU

AUTHORIZATION OF INTEREST REFUND

Collecting Office Name: Nueces County Tax Assessor Collector's Office

City, State, Zip Code: Nueces County Courthouse, 901 Leopard, Suite 301, Corpus Christi TX 78401

Collecting Tax For: Nueces County Hospital

IDENTIFICATION OF PROPERTY OWNER:

Owner: Occidental Chemical, Oxy Ingleside Energy Center, Oxy Ingleside LPG Terminal LLC
Oxy Ingleside Oil Terminal LLC

To be refunded 11/21/2019

Account Number	Year	Description	Amount of Interest Refund
IO-6058000-0110	2012-2017	Loading Pier & Docks	$ 901.28
IO-0003998-0500	2013-2017	Pier @ Former Naval Stat ING	$ 14,781.00
IO-6058000-0115	2013-2017	Barge Docks-2	$ 180.26
IO-0004779-0510	2016-2017	LPG Loadout @ Alpha Pier	$ 721.02
IO-0005061-0500	2017	Oil Loadout @ Alpha Pier	$ 1,442.05
		Total	**$ 18,025.61**

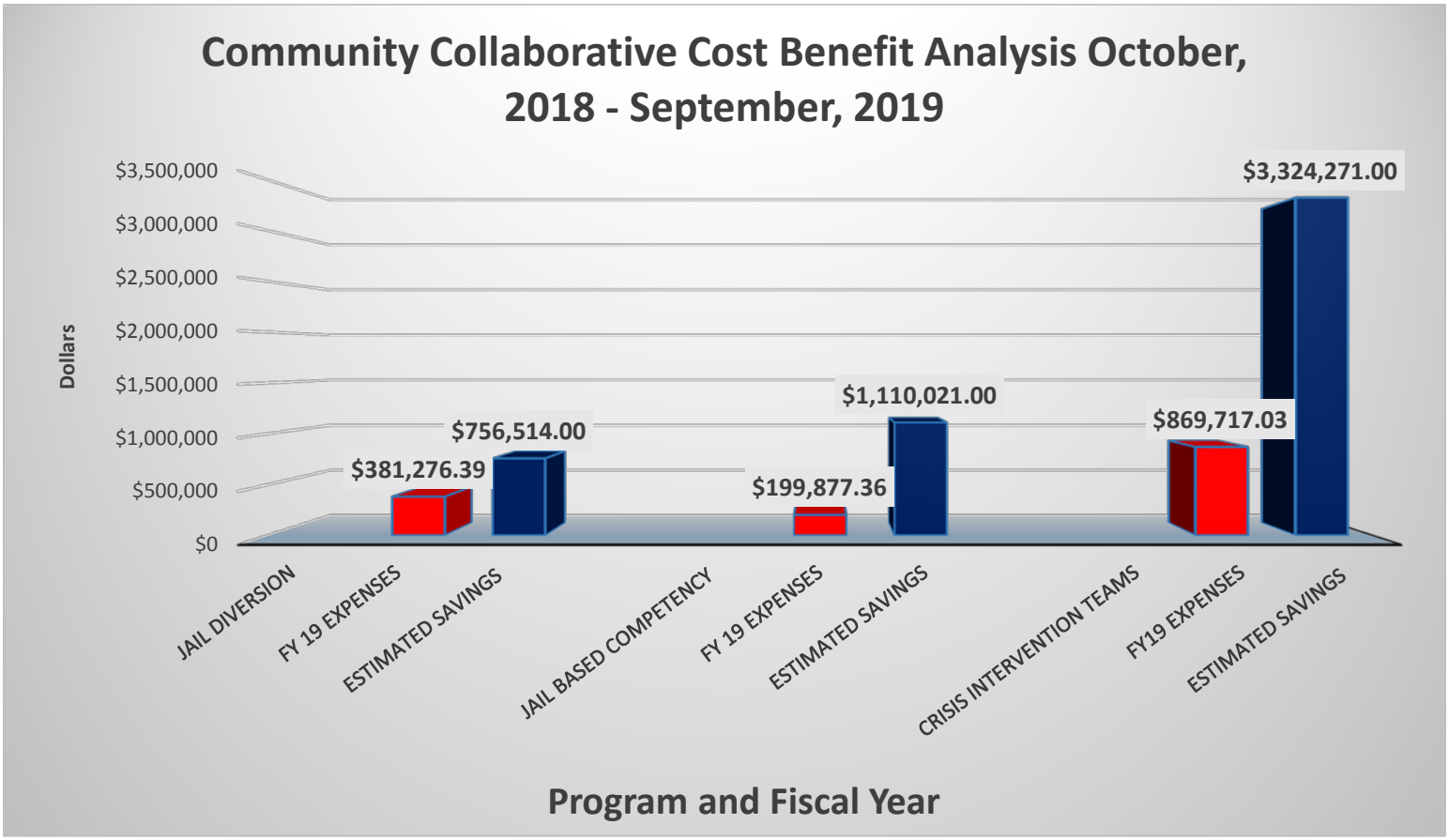
AUTHORIZATION OF INTEREST REFUND

Signature of Aurthorized Officer(s) of Taxing Unit(s) for refunds over $500

11/20/2019
Date

MHID
Since 1969
Nueces Center for
Mental Health and Intellectual Disabilities

Nueces County Community Collaborative Project Update



Jail Diversion			JBCR			CIT	
FY19 Est. Savings	$756,514.00		**FY 19 Est. Savings**	$1,110,021.00		**FY19 Est. Savings**	$3,324,271.00
FY 19 Expenses	$381,276.39		**FY 19 Expenses**	$199,877.36		**FY19 Expenses**	$869,717.03

Total Project Expenses	$1,658,635.48
Est. Savings less expense	$3,739,935.22

Jail Diversion Program: In partnership with the District Attorney's office and Sheriff's Office, Jail Diversion serves to identify and divert individuals with mental illness from the Nueces County Jail who are deemed appropriate for diversion by the District Attorney's office. These are individuals identified as having significant mental health issues which have contributed to their interaction with the criminal justice system. Upon approval for the program individuals are released on a personal recognizance bond with conditions to participate in mental health treatment. Individuals who do not participate in treatment or who recidivate are returned to custody and their charges are reinstated.

Crisis Intervention Teams: In partnership with CCPD and Charlie's Place Recovery Center, CIT provides rapid response, assessment and linkage to ongoing care as quickly as possible. The team consists of crisis intervention trained officers and the Center's mental health professionals. The teams respond to mental health related calls coming in through the 911 system and directly over the radio at law enforcement request. These teams are a critical component which provide a mechanism to reroute individuals from arrest/incarceration into respite services with the Center, substance abuse treatment at Charlie's Place Recovery Center, or ongoing outpatient treatment at the point of potential arrest. Without CIT intervention, most of these individuals would not have been able to access care and would have ended up in jail or inpatient care. Many of these individuals have engaged in treatment thanks to the response, outreach, and follow up of the CIT teams.

Jail Based Competency Restoration: In partnership with the County Jail, Sheriff's Office, and District Attorney's Office, The Jail Based Competency Restoration program serves to restore competency to individuals deemed incompetent to stand trial as a result of their mental illness. The program allows for restoration services to occur rapidly and efficiently so that eligible individuals are not languishing in jail awaiting a state hospital bed. Restoration time for our program has averaged 56 days from enrollment to restoration. This is in contrast to the wait time average of 196 days for a state hospital bed, and another 6-8 months for restoration once these individuals are granted a bed at a state facility.

Services Provided:

- Crisis assessment and intervention – Case Managers
- Psychiatric Medication Management – MD Psychiatrists, Nurse Practitioners
- Psychiatric Nursing Services – LVN's and CMA's
- Case Management – Case Managers
- Psychosocial Rehabilitation – Case Managers
- Crisis Respite Services – Rehab Therapist Technicians, LVN.
- Supported Employment Services – Vocational Specialist, Case Managers.
- Supported Housing Services – Case managers.
- Skills Training – Case managers.
- Medication Management Education – Case managers, LVN's, CMA's.
- Residential Substance Abuse Treatment – Charlie's Place
- Detox Services – Charlie's Place
- Outpatient Substance Abuse Treatment – Charlie's Place
- Benefit Eligibility and Application – Case managers, Consumer Benefit Specialists.
- Competency Restoration – Case Managers, Licensed Practitioners of the Healing Arts (Counselors)

- Competency Assessment – MD Psychiatrist, PHD Psychologist.

Preliminary Report on Prevalence and Hospital/Emergency Department Utilization in Nueces County

FINAL REPORT

December 2019

MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Contents

Introduction

In September 2019, Nueces County and the Nueces County Hospital District (NCHD) engaged the Meadows Mental Health Policy Institute (MMHPI) to conduct a comprehensive mental health needs assessment to inform the County's efforts to improve mental health services for residents. As provided in the contract, we committed to producing a preliminary report on prevalence and hospital/emergency department utilization study by November 30, 2019.

The goal of this preliminary report is to provide a deeper understanding of prevalence, comorbid conditions (including substance use issues/disorders), existing provider capacity, and reimbursement issues in Nueces County. This report is extensive. As such, we encourage Nueces County and NCHD to share this report with their own internal data-savvy staff and we welcome questions and concerns regarding what we have laid out in this preliminary report. This feedback will be incorporated in and improve the final comprehensive needs assessment, which will be completed in June 2020.

Please note that Appendix 1 and Appendix 2 present detailed discussions of the methodology and data sources used in these analyses.

Summary of Key Results

Demographics and Mental Health Prevalence

Necessary treatment capacity depends in part on the number of people with behavioral health needs, which in turn changes with the size of various populations (for example, adults, or children and youth). For this reason, we begin our analysis with population estimates by demographic group, including age, sex, and race/ethnicity, and projected populations through 2050. Estimates of people living with mental and behavioral health conditions are also included. We have included breakouts by diagnosis and counts of people living in poverty who have serious emotional disturbances or serious mental illnesses. These estimates are reported in Tables 1 through 12.

The demographic data show that across all ages, the majority of the population living in Nueces County is Hispanic or Latino (73% of children and youth and 60% of adults) and a higher proportion of Hispanic or Latino people live in poverty than non-Hispanic Whites (Table 2 and Table 8). By the year 2050, the population of children and youth in Nueces is expected to *increase* by 29% from the 2017 population (Table 3). Meanwhile, the adult population is expected to increase by 41% by 2050, with the older adult population growing faster (59% increase) than other adult populations (38% increase) (Table 9). Based on these projections, the underlying need for behavioral health services for children and youth in Nueces County should show modest growth through 2050, while the need for behavioral health services for older adults may increase disproportionately to other age groups.

We estimate that about 25,000 children and youth in Nueces County have any mental health need, with approximately 5,000 of whom having a serious emotional disturbance (SED) (Table 5). Of those children and youth with SED, just over half are living in poverty. Among Nueces adults, slightly less than one-quarter (about 65,000) of the population is expected to have any mental illness (Table 11). About 10,000 to 15,000 are cases of serious mental illness, more than half of whom are living in poverty. We also estimate that approximately 200 adults living in the county have a high level of impairment that leads to frequent use of crisis resources such as hospitals, emergency rooms, and jails. Oftentimes, these people can benefit from intensive outpatient practices such as Assertive Community Treatment (ACT).

In the Local Mental Health Authority Utilization section of this report, we provide actual counts of people served, by level of care, at Behavioral Health Center of Nueces County, and contrast these counts to the estimated number of people living in poverty who have an SED or SMI (Tables 13 through 18). In this section we find that there is a large gap in care for children and youth with serious emotional disturbance (SED) who are living in poverty. We also find that just 34% of adults in need received care through the LMHA.

Utilization of Emergency Departments for Behavioral Health Crises

Because emergency departments (ED) are required to provide treatment to anyone seeking help, the characteristics of behavioral health patients seeking care are good indicators of those people in the community who experience behavioral health crises. Tables 19 through 25 report ED utilization by Nueces County residents. We found that people were over five times more likely to visit the ED for psychiatric diagnoses than for substance use disorder (SUD) diagnoses (Table 19). This ratio matches the prevalence data, which show that prevalence of all mental health conditions is about five times that of SUD (Table 12).

In this analysis, we also found that self-pay and Medicare patients are less likely to receive inpatient care after visiting an ED. A comparison of all psychiatric ED visits (Table 19) to psychiatric ED visits that resulted in inpatient hospitalization (Table 24) shows that people who are self-funded or funded through Medicare receive inpatient care less frequently after visiting an ED, whereas people with commercial insurance receive care more frequently when compared to payer proportions among total psychiatric ED visits. As with other information on payers, we encourage the local hospitals to confirm these results.

Utilization of Inpatient Psychiatric Beds

Tables 26 through 30 report inpatient bed use everywhere in Texas by Nueces County residents, and, separately, use of Nueces County inpatient psychiatric beds by residents of all Texas counties. Our analysis focuses on identifying whether sufficient beds exist locally to serve

all the needs of Nueces County residents and assessing the impact that insufficient community-based outpatient services capacity has on bed use.

We found that two hospitals in surrounding counties have not provided psychiatric inpatient care for more than a year (and one closed because of Hurricane Harvey), though hospitals in the Nueces County area do not appear to have a shortage of inpatient capacity (Table 30). As compared to residents in the Nueces County area who seek inpatient care elsewhere, a larger number of non-Nueces County residents seek care at Nueces County hospitals. A comparison of daily utilization to staffed capacity shows that on most days in the last few years, area hospitals had unused beds.

Although there appears to be enough local capacity overall, inpatient admissions by people with less generous funding sources may be straining local resources. People visiting the ED and who are then placed in a psychiatric bed are more often placed in local beds when they are self-funded and in non-local beds when they are funded through commercial insurance. This is true for people who were hospitalized immediately after visiting a Nueces County ED (Table 24) and among all Nueces County residents who received inpatient psychiatric care (Table 29).

Nueces County Community Demographics and Prevalence Data

Adults, children, and youth have distinct but overlapping behavioral health needs and systems of care. The capacity needed in each system depends on the number of people with behavioral health needs, which changes with the size of each population. For this reason, we begin our preliminary analysis of Nueces County with a demographic description of the adult, children, and youth population sizes and projected future growth rates for each. Because people living in poverty often have higher rates of behavioral health needs and are dependent on the publicly funded behavioral health system, we provide additional data on the number of people living in poverty within each group and the number of these people with the most severe forms of mental illness.

We obtained demographic and population data from the U.S. Census Bureau's 2017 American Community Survey. Population growth projections for adults, children, and youth are from The Texas Demographic Center. Tables 1 through 6 present data on children and youth, whereas tables 7 through 13 cover adults. We provide detailed tables for Nueces County and summarized data for counties in the surrounding region for comparison (Jim Wells, Kleberg, and San Patricio counties). Tables in later sections report all ages, except where breakouts are provided by age group.

Child and Youth Demographics and Behavioral Health Conditions

Table 1, below, provides detailed population estimates with a demographic breakdown (including age, sex, race, and ethnicity) of children and youth in Nueces County. Because the prevalence of behavioral healthcare needs for young children is poorly understood, and very few receive any type of treatment, we do not provide population data for children under the age of six. We summarize these estimates in Table 2 and provide comparison summaries of the surrounding Kleberg, San Patricio, and Jim Wells counties.

As reported in Table 1, the population of Nueces County is predominantly Hispanic or Latino, evenly split between male and female youth, with approximately half of children and youth living below 200% of the federal poverty level. Table 2 shows that 73% of Nueces County children and youth are Hispanic or Latino, but this population makes up 84% of the poverty population, indicating a higher rate of poverty for this demographic group than for Non-Hispanic White children, who make up 21% of the total population but only 10% of the poverty population. In addition, children and youth between the ages of six and 11 make up just under half (49%) of the total population but account for 52% of the poverty population, whereas the reverse is true for older children between the ages of 12 and 17. Thus, younger children are slightly more likely to live in poverty than are older children and youth in Nueces County.

Compared to the surrounding counties of Kleberg, San Patricio, and Jim Wells, Nueces County is generally demographically similar to the larger region – predominantly Hispanic/Latino, evenly split by age group and sex. However, Jim Wells and Kleberg counties have a higher percentage of Hispanic and Latino children (84%) compared to Nueces County children and youth (73%), whereas San Patricio County has a lower percentage of Hispanic and Latino children (63%). Across all counties, Hispanic and Latino children make up a higher proportion of the poverty population than of the total population, whereas Non-Hispanic White children make up a lower proportion of the poverty population relative to the total population.

Table 1: Demographics of Children and Youth in Nueces County (2017)[1]

Population	Total Population	Total Population with SED	Total in Poverty[2]	Total with SED in Poverty
Children and Youth (6–17)	60,000	5,000	30,000	3,000
Age				
Ages 6–11	30,000	2,000	15,000	1,000
Ages 12–17	30,000	2,000	15,000	1,000
Sex				
Male	30,000	2,000	15,000	1,000
Female	30,000	2,000	15,000	1,000
Race/Ethnicity				
Non-Hispanic White	15,000	900	3,000	300
African American	2,000	200	1,000	100
Asian American	1,000	80	300	30
Native American	70	<6	0	0
Multiple Races	600	40	200	20
Hispanic/Latino	45,000	4,000	25,000	2,000

[1] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[2] "In poverty" refers to the estimated number of people below 200% of the federal poverty level for the specified region.

Table 2: Summary Demographics of Children and Youth in Nueces, Jim Wells, Kleberg, and San Patricio Counties (2017)[3]

Population	Nueces		Jim Wells		Kleberg		San Patricio	
Total Population	**Total Pop.**	**Total Poverty**	**Total Pop.**	**Total Poverty**	**Total Pop.**	**Total Poverty**	**Total Pop.**	**Total Poverty**
All Children and Youth	60,000	30,000	7,000	4,000	5,000	3,000	10,000	6,000
Age	**% of Total Pop.**	**% of Total Poverty**	**% of Total Pop.**	**% of Total Poverty**	**% of Total Pop.**	**% of Total Poverty**	**% of Total Pop.**	**% of Total Poverty**
Ages 6–11	49%	52%	48%	53%	48%	53%	49%	51%
Ages 12–17	51%	48%	52%	47%	52%	47%	51%	49%
Sex								
Male	51%	51%	51%	49%	51%	49%	51%	47%
Female	49%	49%	49%	51%	49%	51%	49%	53%
Race/Ethnicity								
Non-Hispanic White	21%	10%	13%	8%	13%	8%	32%	20%
African American	4%	4%	1%	1%	1%	1%	2%	1%
Asian American	2%	1%	1%	0%	1%	0%	0%	0%
Native American	0%	0%	0%	0%	0%	0%	0%	0%
Multiple Races	1%	1%	0%	0%	0%	0%	3%	4%
Hispanic/Latino	73%	84%	84%	90%	84%	90%	63%	74%

[3] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. The reported percentages are calculated using unrounded estimates. Because of this rounding process, the reported percentages may not equal percentages calculated using rounded estimates.

Table 3, below, shows projected population change among children and youth in Nueces County. The population of children and youth is expected to *increase* by more than 17,000 children and youth – from about 62,000 in 2017 to 79,000 in 2050. This represents a 30% increase by 2050, with a slightly higher increase among children ages six to 11 (30%) compared to youth ages 12 to 17 (27%). In comparison, as Table 4 reports, the child and youth population of San Patricio County is expected to increase by only 11%, whereas in Jim Wells County, the population is expected to remain at 2017 levels. Meanwhile, in Kleberg County, the population of children and youth is expected to *decrease* by 11% through 2050.

Based on these projections, the underlying need for behavioral health services for children and youth in Nueces County should show modest growth through 2050, with little to no growth in surrounding counties. In the full report that we will submit at the end of this assessment, there will be a description of how well the current system of care addresses the needs of children and youth.

Table 3: Estimated Population of Children and Youth in Nueces County – 2017 through 2050[4]

Year	Children Ages 6 to 11		Youth Ages 12 to 17		All Children and Youth	
	Population	Percentage Change from 2017	Population	Percentage Change from 2017	Population	Percentage Change from 2017
2017	**30,372**		**31,346**		**61,718**	
2020	31,600	4%	31,369	0%	62,969	2%
2025	34,466	13%	32,682	4%	67,148	9%
2030	36,399	20%	35,705	14%	72,104	17%
2035	37,121	22%	37,863	21%	74,984	21%
2040	37,354	23%	38,825	24%	76,178	23%
2045	38,153	26%	39,053	25%	77,206	25%
2050	39,606	30%	39,714	27%	79,320	29%

[4] Estimated 2017 populations obtained from the 2017 American Community Survey population estimates. Projected population change was obtained from: Texas Demographic Center (2018). *Texas Population Projection Program – Age, Sex, and Race/Ethnicity (ASRE) Population [Excel file].* Retrieved from: demographics.texas.gov/Data/TPEPP/Projections/

Table 4: Estimated Population of Children and Youth in Jim Wells, Kleberg, and San Patricio Counties – 2017 through 2050[5]

Year	Jim Wells		Kleberg		San Patricio	
	Child and Youth Population	Percentage Change from 2017	Child and Youth Population	Percentage Change from 2017	Child and Youth Population	Percentage Change from 2017
2017	**7,190**		**5,481**		**11,038**	
2020	7,412	3%	5,086	-7%	10,946	-1%
2025	7,792	8%	4,445	-19%	11,281	2%
2030	7,906	10%	4,239	-23%	11,943	8%
2035	7,656	6%	4,614	-16%	12,428	13%
2040	7,344	2%	4,779	-13%	12,484	13%
2045	7,193	0%	4,568	-17%	12,331	12%
2050	7,154	0%	4,227	-23%	12,258	11%

Because accessing behavioral health services often depends on geographic factors such as travel time, it is important to know where children and youth with behavioral health needs live in Nueces County.

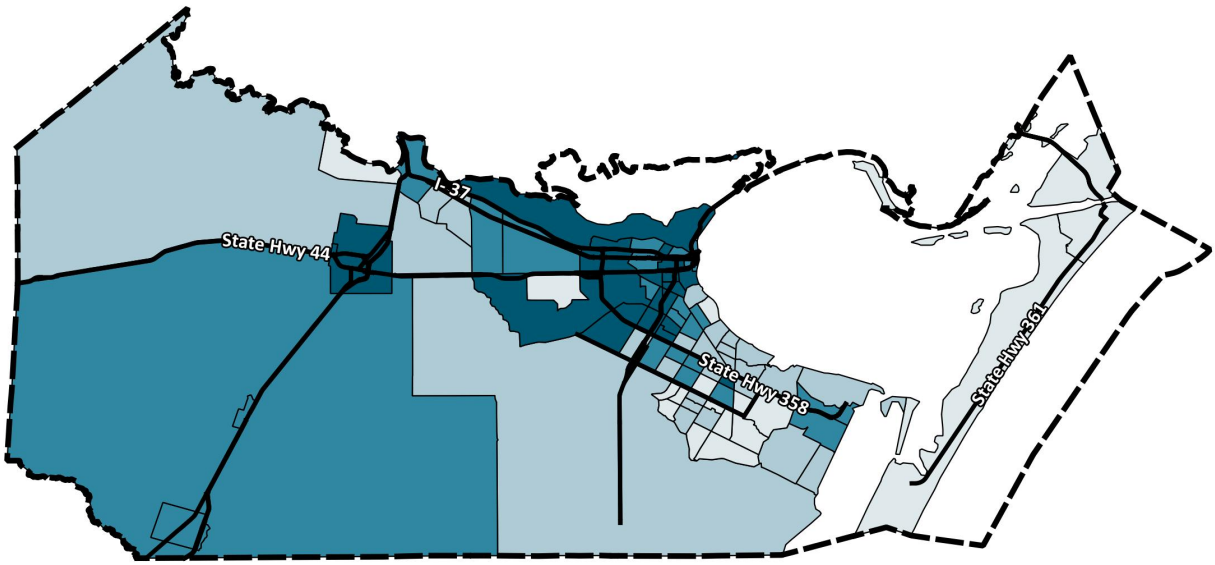
Maps 1 through 5, below, show subdivisions of counties, called "census tracts," in Nueces County. Census tracts are shaded according to several factors: overall social vulnerability (Map 1), the count of children and youth in poverty (Map 2), the change in the number of children and youth in poverty from 2012 to 2017 (Map 3), the count of Hispanic/Latino people of all ages (Map 4), and the change in the number of Hispanic/Latino people from 2012 to 2017 (Map 5).

Map 1 shows each census tract in Nueces County, ranked by overall social vulnerability from the Center for Disease Control and Prevention's (CDC) Social Vulnerability Index (SVI). Social vulnerability is determined based on 15 factors in each community that are grouped into four major themes: socioeconomic status, household composition and disability, minority status and language, and housing and transportation. We then ranked and categorized the overall vulnerability ratio for all census tracts in the Nueces County in comparison with one another: first quartile (lowest vulnerability), second quartile, third quartile, and fourth quartile (highest vulnerability). As the map shows, communities near Corpus Christi, where I-37 meets the coast,

[5] Estimated 2017 populations obtained from the 2017 American Community Survey population estimates. Projected population change was obtained from: Texas Demographic Center (2018). *Texas Population Projection Program – Age, Sex, and Race/Ethnicity (ASRE) Population [Excel file].* Retrieved from: demographics.texas.gov/Data/TPEPP/Projections/

are ranked as high vulnerability (dark blue) as are the communities near Robstown off State Highway 44. In contrast, Port Aransas/Mustang Island along State Highway 361 and the communities in the south-central part of Nueces County are low vulnerability communities (light blue).

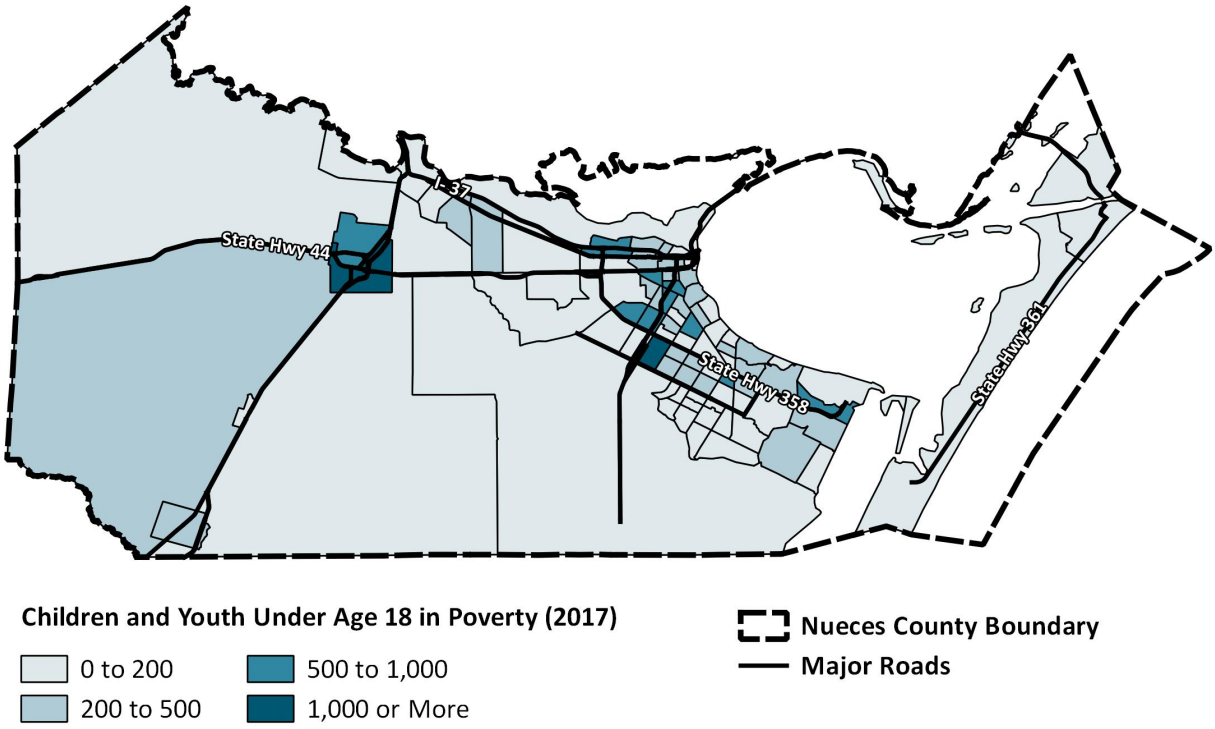
Map 1: Social Vulnerability Index. by Census Tract (2016)[6]



Similarly, Map 2 shows counts of children and youth in poverty by census tract, with dark blue areas signifying regions with high counts of children and youth in poverty as compared to the overall county. As reported in Map 1, the region near Corpus Christi/Robstown in Map 2 has tracts with high counts of children and youth in poverty, whereas Port Aransas has lower counts of children and youth in poverty.

[6] Obtained from the Centers for Disease Control and Prevention (CDC) 2016 Social Vulnerability Index (SVI). We used the "RPL_Themes" variable as a composite indicator for overall social vulnerability. Retrieved from https://svi.cdc.gov/Documents/Data/2016_SVI_Data/SVI2016Documentation.pdf

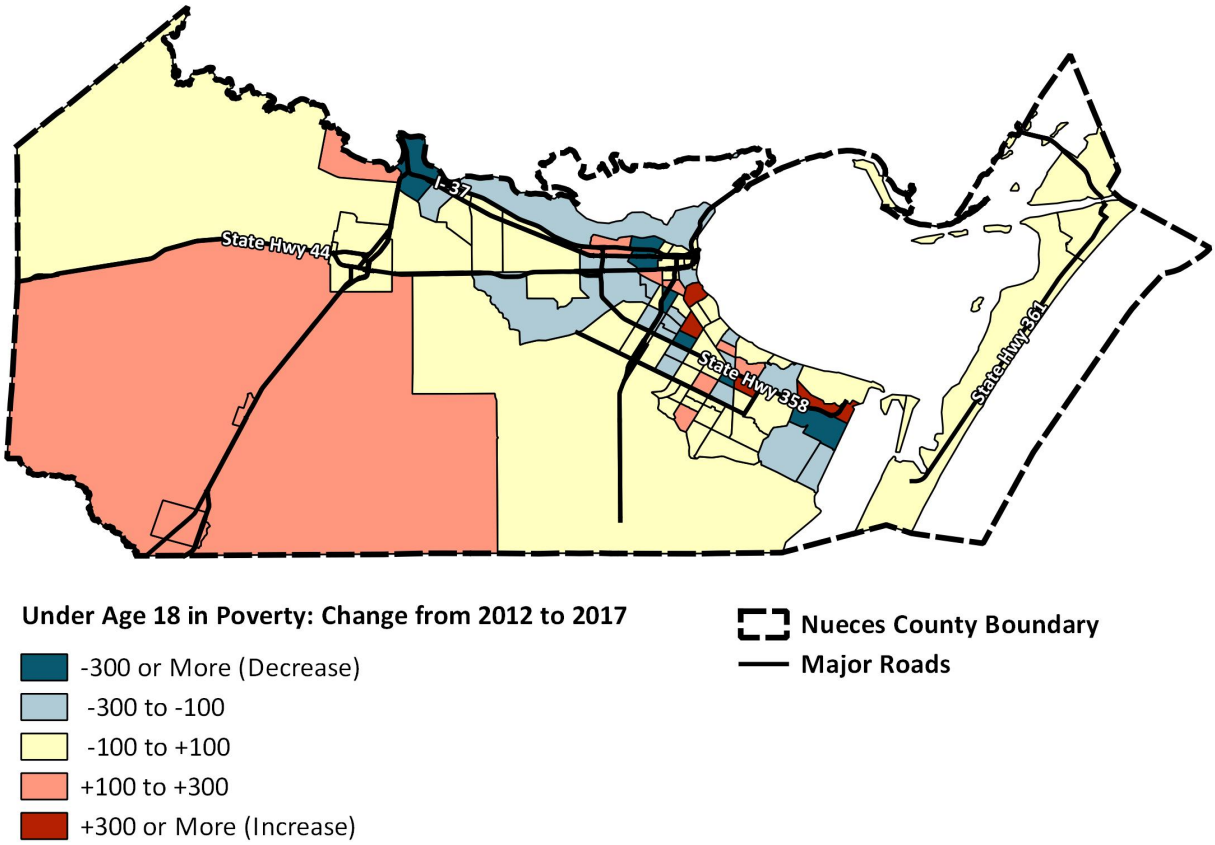
Map 2: Children and Youth Under Age 18 in Poverty, by Census Tract (2017)[7]



Map 3, below, shows the change of the population of children and youth living in poverty from 2012 to 2017. Areas in pink and red show pockets where the count of children and youth living in poverty increased, whereas areas in blue show locations where the number of children and youth in poverty decreased. Yellow regions show where the population in poverty remained stable. Overall, the large region in the bottom left corner of the map (southeast Nueces County) showed a modest increase in poverty. Near Corpus Christi, along State Highway 358, are multiple areas with substantial increases in the poverty population in close proximity to areas with substantial decreases in poverty. This distinction shows that communities that are rapidly increasing (and decreasing) in poverty are highly localized.

[7] Poverty data obtained from the U.S. Census Bureau, American Community Survey 2015 Five-Year Estimates. Table S1701: Poverty Status in the Past 12 Months. Retrieved from https://factfinder.census.gov

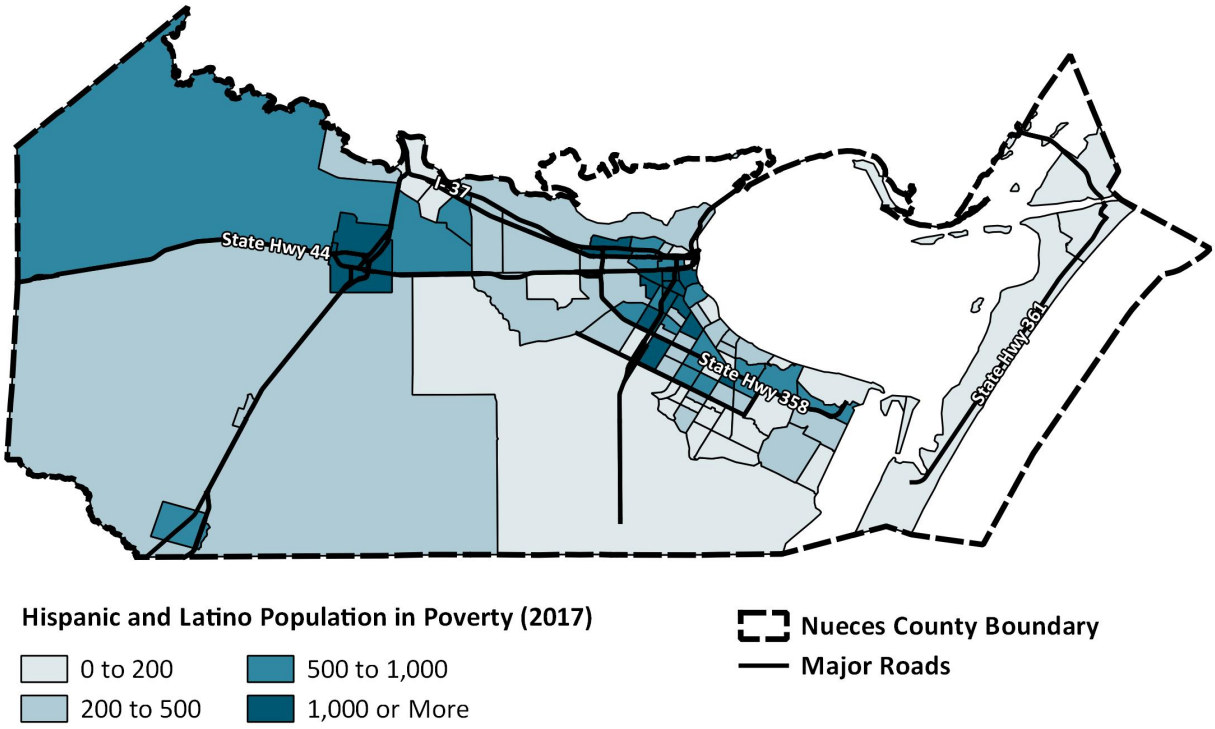
Map 3: Children and Youth Under Age 18 Change in Poverty, by Census Tract (2012 to 2017)



Similar to Map 2, Map 4 shows demographic counts by census tract. This map reports the counts of Hispanic/Latino children and youth across Nueces County. The region near Corpus Christi, where I-37 meets the coast, and the region off of State Highway 44 both have high counts of Hispanic/Latino people.

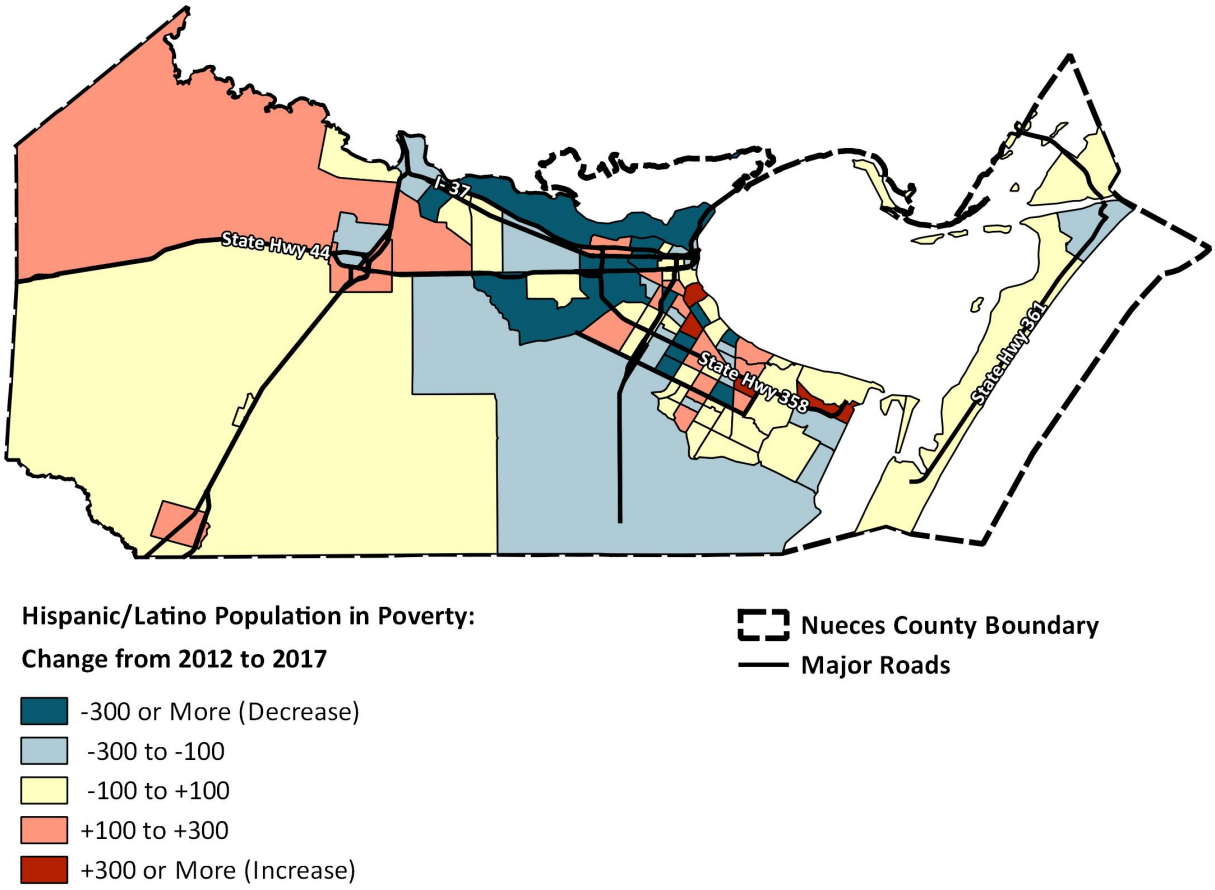
From 2012 to 2017, as Map 5 shows, the count of Hispanic and Latino people increased substantially along State Highway 358 in Corpus Christi, as well as in the northeast portion of the county. When planning for services to meet the needs of this population, it may be useful to consider where providers are located in contrast to those in need. For example, planning may consider whether there are any Spanish-speaking providers and, if so, whether they are located in proximity to the Spanish-speaking population.

Map 4: Hispanic/Latino Population in Poverty, by Census Tract (2017)[8]



[8] Poverty data obtained from the U.S. Census Bureau, American Community Survey 2015 Five-Year Estimates. Table S1701: Poverty Status in the Past 12 Months. Retrieved from https://factfinder.census.gov

Map 5: Hispanic/Latino Population Change in Poverty, by Census Tract (2012 to 2017)



The next two tables provide prevalence estimates of various mental health conditions (Table 5) and substance use disorders (Table 6) among children and youth in Nueces County alongside comparisons to neighboring counties.

Table 5 shows that there are about 25,000 children and youth in Nueces County with any mental health needs. In comparison, Jim Wells, Kleberg, and San Patricio are smaller counties with approximately 3,000, 2,000, and 4,000 children and youth with mental health needs (respectively). In Nueces County specifically, of the children and youth with mental health needs, more than half (15,000) are expected to have mild conditions, whereas about 5,000 ae expected to have moderate conditions and another 5,000 are expected to have mental health needs that cause enough impairment to be considered serious emotional disturbance (SED). Of those children and youth with SED, just over half (3,000) are living in poverty. The most severe conditions – causing so much impairment that the child or youth is at risk for out-of-home or out-of-school placement or involvement in the child welfare system – are expected to affect about 300 children and youth in the region. These children and youth may benefit from

intensive wraparound care that could be provided at the local mental health authority through YES waiver services.

The estimated number of children and youth with adverse childhood experiences (ACEs) are also included in Table 5. Experiences of abuse or neglect; having incarcerated parents; and witnessing intimate partner violence, substance misuse, or mental illness within the home are all considered adverse childhood experiences. These types of stressful and traumatic events are correlated with a range of health problems throughout life, including substance use, behavioral health, and physical health conditions.[9] About 9,000 children and youth in Nueces County are expected to have experienced three or more ACEs and have a much higher risk for health problems, including mental illness, later in life.

It is also worth noting that there are relatively few anticipated new cases of first episode psychosis (FEP) in a given year. This comparatively small number makes intervention possible, assuming appropriate capacity to identify and treat individuals experiencing FEP; this is something we will address in detail in the full report.

Table 5: Twelve-Month Prevalence of Mental Health Disorders in Children and Youth in Nueces County (2017)

Mental Health Condition – Children and Youth	Age Range	Prevalence[10]			
		Nueces	Jim Wells	Kleberg	San Patricio
Total Population	**6–17**	**60,000**	**7,000**	**5,000**	**10,000**
Population in Poverty[11]	6–17	30,000	4,000	3,000	6,000
All Mental Health Needs (Mild, Moderate, and Severe)[12]	**6–17**	**25,000**	**3,000**	**2,000**	**4,000**
Mild	6–17	15,000	2,000	1,000	2,000
Moderate	6–17	5,000	600	500	1,000

[9] SAMHSA-HRSA Center for Integrated Health Solutions. (n.d.). *Trauma.* Retrieved from https://www.integration.samhsa.gov/clinical-practice/trauma-informed

[10] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[11] "In poverty" refers to the estimated number of people below 200% of the federal poverty level for the specified region.

[12] Kessler, R. C., et al. (2012)a. Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, 69(4), 372–380, and Kessler, R. C., et al. (2012)b. Severity of 12-Month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, 69(4), 381–389.

Mental Health Condition – Children and Youth	Age Range	Prevalence[10]			
		Nueces	Jim Wells	Kleberg	San Patricio
Severe – Serious Emotional Disturbance (SED)[13]	6–17	5,000	600	400	900
SED in Poverty	6–17	3,000	400	300	500
At Risk for Out-of-Home/Out-of-School Placement[14]	6–17	300	40	30	50
Specific Disorders – Youth[15]					
Depression	12–17	3,000	300	200	500
Bipolar Disorder	12–17	700	80	60	100
Post-Traumatic Stress Disorder	12–17	1,000	100	100	200
Schizophrenia[16]	12–17	70	<10	<10	10
First Episode Psychosis (FEP) Incidence – New Cases per Year[17]	12–17	10	<6	<6	<6
Obsessive-Compulsive Disorder – Children/Youth[18]	6–17	1,000	100	100	200

[13] Local prevalence estimates of SED are drawn from Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Dallas, TX: Meadows Mental Health Policy Institute.

[14] MMHPI estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These youth need intensive family- and community-based services.

[15] Unless otherwise specified, local prevalence estimates of specific mental health conditions among youth are drawn from the 12-month prevalence rates reported in Kessler, R. C., et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 372–380.

[16] Local prevalence estimates of schizophrenia are drawn from the 12-month prevalence rates reported in Androutsos, C. (2012). Schizophrenia in children and adolescents: Relevance and differentiation from adult schizophrenia. *Psychiatriki, 23*(Supl), 82–93 (original article in Greek). Androutsos estimates that among youth ages 13–18, 0.23% meet criteria for the diagnosis of schizophrenia.

[17] Local incidence estimates of first episode psychosis are drawn from the 12-month prevalence rates reported in Kirkbride, J. B., et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry, 174*, 143–153.

[18] Local prevalence estimates of obsessive-compulsive disorders are drawn from the 12-month prevalence rates reported in Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. *Dialogues in Clinical Neuroscience, 13*(4), 401–411; Peterson, B., et al. (2001). Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(6), 685–695; and Douglas, H. M., et al. (1995). Obsessive-compulsive disorder in a birth cohort of 18-year-olds: Prevalence and predictors. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(11), 1424–1431.

Mental Health Condition – Children and Youth	Age Range	Prevalence[10]			
		Nueces	Jim Wells	Kleberg	San Patricio
Eating Disorders[19]	12–17	300	30	20	40
Self-Injury/Harming Behaviors[20]	12–17	3,000	400	300	500
Conduct Disorder	12–17	2,000	200	200	300
Number of Deaths by Suicide[21]	0–17	<10	<10	<10	<10
Specific Disorders – Children Only					
All Anxiety Disorders – Children	6–11	3,000	400	300	600
Depression/All Mood Disorders – Children	6–11	300	30	30	50
Children and Youth with Adverse Childhood Experiences (ACEs)[22]					
Population with 1 or 2 ACEs	0–17	30,000	4,000	3,000	7,000
Population with 3 or More ACEs	0–17	9,000	1,000	800	2,000

Table 6 provides an overview of the estimated number of youth with substance use disorders in Nueces and surrounding counties. Based on the latest available data from the National Survey on Drug Use and Health region-specific estimates, we expect there to be approximately 1,000 youth in Nueces County with substance use disorders, with much lower counts in the smaller surrounding counties. Slightly more than half (700) are living in poverty, and slightly fewer than half (300) have co-occurring psychiatric and substance use disorders.

[19] Local prevalence estimates of eating disorders are drawn from the 12-month prevalence rates reported in Swanson, S. A., et al. (2011). Prevalence and correlates of eating disorders in adolescents: Results from the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 68*(7), 714–723. The prevalence estimate for eating disorders encompasses only Anorexia Nervosa and Bulimia Nervosa.

[20] Local prevalence estimates of self-harming and self-injury behaviors are drawn from the 12-month prevalence rates reported in Muehlenkamp, J. J., et al. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health,* doi: 10.1186/1753-2000-6-10

[21] Death by suicide data obtained from Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2017 on CDC WONDER Online Database.

[22] Local prevalence estimates of adverse childhood experiences are drawn from state-level 12-month prevalence rates reported in Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence (research brief No. 2014–28)*. Bethesda, Maryland: Child Trends. Retrieved from https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

Table 6: Prevalence of Substance Use Disorders (SUD) Among Youth Ages 12 to 17 (2017)[23,24]

Population	Nueces	Jim Wells	Kleberg	San Patricio
Total Population	**30,000**	**4,000**	**3,000**	**6,000**
Total Population in Poverty	15,000	2,000	1,000	3,000
Any Substance Use Disorder	**1,000**	**100**	**100**	**200**
SUD in Poverty[25]	700	90	70	200
Comorbid Psychiatric and SUD[26,27]	300	40	30	70
Needing but Not Receiving Treatment for Substance Use	1,000	100	90	200
Alcohol-Related SUD	**500**	**50**	**40**	**90**
Needing but Not Receiving Treatment for Alcohol Use	500	50	40	90
Illicit Drug-Related SUD	**800**	**80**	**70**	**200**
Needing but Not Receiving Treatment for Illicit Drug Use	700	80	70	100
Number of Drug-Related Deaths in 2017[28]	**<10**	**<10**	**<10**	**<10**
Number of Alcohol-Induced Deaths in 2017[29]	**N/A**	**N/A**	**N/A**	**N/A**

[23] Unless otherwise specified, estimated prevalence of substance use disorders are based on prevalence rates are drawn from 2016–2017 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[24] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying Texas Demographic Center population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[25] The prevalence of any substance use disorder among adults and youth living in poverty is drawn from the national prevalence rate of alcohol or illicit drug dependence among those living at 199% ,or less, of the federal poverty level according to results from the National Survey on Drug Use and Health, 2014.

[26] The local prevalence of co-occurring psychiatric and substance abuse disorders among adults are based on the intersection between the national prevalence rate of any mental illness and substance use disorder, as reported in SAMHSA's 2018 *Behavioral Health Trends in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53) report and the 2016–2017 National Survey on Drug Use and Health (NSDUH) rates of SMI for Texas.

[27] The local prevalence of comorbid psychiatric and substance use disorders among youth ages 12–17 is based on intersection between the national prevalence rate of major depressive episodes and SUD, as reported in SAMHSA's 2018 *Behavioral Health Trends in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53) report and the 2014–2016 National Survey on Drug Use and Health (NSDUH) sub-state rates of MDE for Texas.

[28] Death by drug overdose data were obtained from Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2017 on CDC WONDER Online Database. Accessed at http://wonder.cdc.gov/mcd-icd10.html. Overdose deaths are classified using underlying cause-of-death ICD-10 codes: X40–44, X60–64, X85, and Y10–Y14.

[29] The number of alcohol-induced deaths were obtained from the Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2017 on CDC WONDER Online Database.

Adult Demographics and Behavioral Health Conditions

Below, Table 7 details population estimates, by demographic group, in Nueces County. We summarize these estimates in Table 8 and provide a comparison to surrounding counties. Overall, as shown in Table 7, about 270,000 adults live in the county. The population is predominantly Hispanic/Latino, with a smaller subset of the population identifying as Non-Hispanic White and smaller counts of African American and other people of color. The population is evenly split by sex and by age group for those above the age of 35. However, the population of young adults (ages 18 to 24) is much smaller than the population of adults between the ages of 25 to 34 (35,000 compared to 55,000).

Table 8 provides summarized demographics to compare to the surrounding counties. As we see in Nueces County, there are fewer young adults in surrounding counties than there are older adults. The population is evenly split between men and women, with higher counts of Hispanic/Latino people compared to people of other race and ethnicity groups – with one exception. In San Patricio County, the population is evenly split between White and Non-Hispanic White people (each make up 47% of the population). For Nueces and surrounding counties, women comprise approximately half of the population but more than half of the poverty population – showing that women are more likely to be living in poverty in Nueces County and the larger region. Similarly, the Hispanic/Latino population makes up a higher proportion of the poverty population relative to the general population, which means that Hispanics and Latinos in the region are disproportionately affected by poverty than is the White population, which makes up less of the poverty population compared to the total population.

Table 7: Demographics of Adults in Nueces County (2017)[30]

Nueces County	Total Population	Total Population with SMI	Total in Poverty[31]	Total with SMI in Poverty
Adult Population 18+	270,000	10,000	90,000	7,000
Age				
18–20	15,000	300	6,000	200

Accessed at http://wonder.cdc.gov/mcd-icd10.html. Alcohol induced deaths are classified using any underlying cause of death and multiple causes of death category, "alcohol-induced causes." In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 are suppressed using values of "<10."

[30] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[31] "In poverty" refers to the estimated number of people below 200% of the federal poverty level for the specified region.

Nueces County	Total Population	Total Population with SMI	Total in Poverty[31]	Total with SMI in Poverty
21–24	20,000	900	9,000	600
25–34	55,000	3,000	20,000	2,000
35–44	45,000	3,000	15,000	2,000
45–54	45,000	2,000	15,000	1,000
55–64	45,000	1,000	10,000	800
65+	50,000	800	15,000	400
Sex				
Male	130,000	5,000	40,000	2,000
Female	140,000	7,000	50,000	5,000
Race/Ethnicity				
Non-Hispanic White	90,000	4,000	20,000	2,000
African American	10,000	600	3,000	300
Asian American	6,000	100	1,000	50
Native American	700	50	400	40
Multiple Races	2,000	100	700	80
Hispanic/Latino	160,000	7,000	65,000	5,000

Table 8: Summary Demographics of Adults in Nueces, Jim Wells, San Patricio, and Kleberg Counties (2017)

Population	Nueces		Jim Wells		Kleberg		San Patricio	
Total Population	**Total Pop.**	**Total Poverty**	**Total Pop.**	**Total Poverty**	**Total Pop.**	**Total Poverty**	**Total Pop.**	**Total Poverty**
All Adults	270,000	90,000	30,000	15,000	25,000	10,000	50,000	15,000
Age	**% of Total Pop.**	**% of Total Poverty**	**% of Total Pop.**	**% of Total Poverty**	**% of Total Pop.**	**% of Total Poverty**	**% of Total Pop.**	**% of Total Poverty**
18–20	6%	7%	8%	9%	8%	9%	5%	8%
21–24	8%	10%	11%	14%	11%	14%	7%	9%
25–34	19%	21%	18%	18%	18%	18%	18%	18%
35–44	16%	15%	16%	14%	16%	14%	16%	15%
45–54	17%	14%	14%	12%	14%	12%	17%	14%
55–64	16%	14%	14%	11%	14%	12%	16%	14%
65+	18%	19%	19%	21%	19%	21%	21%	22%

Population	Nueces		Jim Wells		Kleberg		San Patricio	
Sex								
Male	49%	42%	51%	44%	51%	44%	53%	43%
Female	51%	58%	49%	56%	49%	56%	47%	57%
Race/Ethnicity								
Non-Hispanic White	33%	23%	18%	13%	18%	13%	47%	36%
African American	4%	4%	2%	2%	2%	2%	4%	2%
Asian American	2%	2%	1%	1%	1%	1%	1%	0%
Native American	0%	0%	0%	0%	0%	0%	0%	0%
Multiple Races	1%	1%	0%	0%	0%	0%	1%	1%
Hispanic/Latino	60%	70%	78%	84%	78%	84%	47%	60%

Table 9 shows the projected population of adults living in Nueces County through 2050. The overall population is expected to increase by 41% by 2050 (from about 270,500 adults in 2017 to 382,500 in 2050), with the older adult population growing faster (59% increase) than other adult populations (38% increase). As a result, the need for behavioral health services for older adults may increase disproportionately to other age groups. In comparison, Jim Wells and San Patricio counties are also expected to see increases in the adult population, though much more moderately than in Nueces County. In contrast, the adult population of Kleberg County is expected to decrease through 2050 (for both adults and older adults).

Table 9: Estimated Population of Adults in Nueces County – 2017 through 2050[32]

Year	Adults Age 18 to 64		Adults Age 65 and Older		All Adults	
	Population	Percentage Change from 2017	Population	Percentage Change from 2017	Population	Percentage Change from 2017
2017	**222,414**		**48,084**		**270,498**	
2020	228,296	3%	52,973	10%	281,270	4%
2025	237,546	7%	60,707	26%	298,254	10%
2030	248,084	12%	66,447	38%	314,531	16%
2035	263,889	19%	67,895	41%	331,785	23%
2040	279,868	26%	69,410	44%	349,278	29%

[32] Estimated 2017 populations obtained from the 2017 American Community Survey population estimates. Projected population change was obtained from: Texas Demographic Center (2018). *Texas Population Projection Program – Age, Sex, and Race/Ethnicity (ASRE) Population [Excel file].* Retrieved from: demographics.texas.gov/Data/TPEPP/Projections/

Year	Adults Age 18 to 64		Adults Age 65 and Older		All Adults	
	Population	Percentage Change from 2017	Population	Percentage Change from 2017	Population	Percentage Change from 2017
2045	294,862	33%	71,436	49%	366,298	35%
2050	305,862	38%	76,615	59%	382,477	41%

Table 10: Estimated Population of Adults (Age 18 to 64) in Jim Wells, Kleberg, and San Patricio Counties – 2017 through 2050[33]

Year	Jim Wells		Kleberg		San Patricio	
	Population	Percentage Change from 2017	Population	Percentage Change from 2017	Population	Percentage Change from 2017
Adults Age 18 to 64						
2017	**24,695**		**18,827**		**40,125**	
2020	24,563	-1%	18,794	0%	41,069	2%
2025	24,334	-1%	18,634	-1%	42,699	6%
2030	24,483	-1%	18,397	-2%	44,340	11%
2035	24,967	1%	17,932	-5%	46,541	16%
2040	25,360	3%	17,628	-6%	48,933	22%
2045	25,565	4%	17,613	-6%	50,900	27%
2050	25,282	2%	17,380	-8%	52,153	30%
Adults Age 65 and Older						
2017	**5,627**		**4,290**		**10,840**	
2020	6,026	7%	4,535	6%	11,831	9%
2025	6,602	17%	4,788	12%	13,047	20%
2030	6,819	21%	4,865	13%	13,903	28%
2035	6,689	19%	4,696	9%	13,860	28%
2040	6,449	15%	4,517	5%	13,430	24%
2045	6,200	10%	4,152	-3%	13,260	22%
2050	6,222	11%	4,010	-7%	13,611	26%

[33] Estimated 2017 populations obtained from the 2017 American Community Survey population estimates. Projected population change was obtained from: Texas Demographic Center (2018). *Texas Population Projection Program – Age, Sex, and Race/Ethnicity (ASRE) Population [Excel file].* Retrieved from: demographics.texas.gov/Data/TPEPP/Projections/

Above, we include core demographic information. This next section provides an overview of the estimated current prevalence or need of different severities of behavioral health conditions as well as specific behavioral health conditions and disorders in Nueces and surrounding counties. Table 11 shows the estimated prevalence of mental health conditions among adults in Nueces and surrounding counties, whereas Table 12 shows the estimated prevalence of substance use disorders.

Overall, there are about 270,000 adults living in Nueces County. Slightly less than one quarter of adults in the region (about 65,000) are expected to have any mental illness. The vast majority of these adults living with mental illness (50,000) are expected to have conditions that are mild to moderate in severity, which can be treated in integrated primary care clinics.[34] The rest, between 10,000 to 15,000, are expected to be people with serious mental illness, more than half of whom (7,000) are living in poverty. These people have mental health conditions that would benefit from treatment in a specialized behavioral health setting, such as treatment provided in community clinics through the local mental health authority. Because of the smaller population sizes, estimates for Jim Wells, Kleberg, and San Patricio counties are much lower than those of Nueces County. We include those estimates in Table 11 for comparison.

The most serious cases of serious mental illness cause a level of impairment that leads to frequent use of crisis resources such as hospitals, emergency rooms, and jails. Often, these people can benefit from intensive outpatient practices such as Assertive Community Treatment (ACT). We estimate that in Nueces County, about 200 adults could benefit from ACT, half of whom may benefit from Forensic ACT because of their involvement in the criminal justice system. In our full report, we will assess and discuss in detail the services that have proven success in sustaining people in community and buffering against the use of emergency departments and jails.

As with children and youth, there are a comparatively small number of anticipated cases of first episode psychosis (FEP) among adults, though the number is larger than anticipated for children and youth.

[34] MMHPI experts estimate that the proportion of the adult population with mental health needs who are best treated in integrated primary care settings is approximately equal to the proportion with mild or moderate severity. Although some portion of people with serious mental illness (e.g., people with major depression) can be effectively treated in integrated primary care, a proportion of people with moderate mental illness need care at specialty settings. These are offsetting factors and approximately cancel each other.

Table 11: Twelve-Month Prevalence: Mental Health Disorders for Adults in Nueces and Surrounding Counties (2017)

Mental Health Condition – Adults	Nueces County[35]	Jim Wells	Kleberg	San Patricio
Total Adult Population	**270,000**	**30,000**	**25,000**	**50,000**
Population in Poverty[36]	90,000	15,000	10,000	15,000
All Mental Health Needs (Mild, Moderate, and Severe)[37]	**65,000**	**7,000**	**6,000**	**15,000**
Mild	25,000	3,000	2,000	5,000
Moderate	25,000	3,000	2,000	5,000
Severe – Serious Mental Illness (SMI) [38]	10,000	2,000	1,000	3,000
SMI in Poverty[39]	7,000	1,000	700	1,000
Complex Needs without Forensic Need (ACT)[40]	100	10	10	20
Complex Needs with Forensic Need (FACT)[41]	100	10	<10	20
Specific Diagnoses				
Major Depression[42]	20,000	2,000	2,000	4,000
Bipolar I Disorder[43]	1,000	200	100	300

[35] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[36] "In poverty" refers to the estimated number of people below 200% of the federal poverty level for the specified region.

[37] Local prevalence estimates behavioral health needs across levels of severity are drawn from 12-month prevalence rates reported in Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of Gen Psychiatry, 62*(6), 617–627.

[38] Local prevalence estimates of SMI are drawn from: Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Dallas, TX: Meadows Mental Health Policy Institute.

[39] "In poverty" refers to the estimated number of people below 200% of the federal poverty level for the specified region.

[40] Local prevalence estimates for the need for ACT are drawn from 12-month prevalence rates reported in Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*(12), 1803–1806

[41] Local prevalence estimates for the need for FACT are drawn from 12-month prevalence rates reported in Cuddeback, G. S., Morrissey, J. P., & Cusack, K. J. (2008). How many forensic assertive community treatment teams do we need? *Psychiatric Services, 59*, 205–208.

[42] Local prevalence estimates for major depression are drawn from 12-month prevalence rates reported from Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Dallas, TX: Meadows Mental Health Policy Institute.

[43] Local prevalence estimates for major depression are drawn from 12-month prevalence rates reported from Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Dallas, TX: Meadows Mental Health Policy Institute.

Mental Health Condition – Adults	Nueces County[35]	Jim Wells	Kleberg	San Patricio
Post-Traumatic Stress Disorder[44]	9,000	1,000	800	2,000
Schizophrenia[45]	1,000	200	100	300
First Episode Psychoses (FEP) Incidence – New Cases per Year (Ages 18–34)[46]	30	<6	<6	<6
Number of Deaths by Suicide[47]	48	10	<10	<10

As shown in Table 12, around 15,000 adults in Nueces County have substance use disorders (SUD), more than half of which (9,000) are expected to be among people living in poverty. About half of all SUD cases are also expected to be instances of co-occurring psychiatric and substance use disorders. In 2017, at least 77 adults died because of drug overdose, and at least 98 adults had alcohol-induced deaths. Statewide data from the national survey on drug use and health show that very few adults who need treatment for substance use disorders receive it (approximately 7%, using data from the National Survey on Drug Use and Health). However, we know that nearly half (46%) of all cases of SUD could be treated in an integrated primary care setting.[48]

Because the Nueces region is not expected to have substantial increases in population among young adults, current prevalence estimates may be a good indicator of need for years to come when planning for the future community need. However, as the demographics shift towards an older population, Nueces County may benefit from additional services that are designed to meet the needs of the older population. This may include addressing issues that lead to health inequities among older adults, such as transportation needs, mobility concerns, and isolation.

[44] Unless otherwise specified, local prevalence estimates of specific conditions are calculated from 12-month prevalence rates reported in Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of Gen Psychiatry, 62*(6), 617–627.

[45] Local prevalence estimates for schizophrenia are drawn from 12-month prevalence rates reported in McGrath, J., et al. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews, 30*, 67–76.

[46] Local incidence estimates for first episode psychosis are drawn from 12-month prevalence rates reported in Kirkbride, J. B., et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry, 174*(2), 143–153.

[47] Death by suicide data obtained from Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2017 on CDC WONDER Online Database. Suicide deaths are classified using underlying cause-of-death ICD-10 codes: X60–84 and Y87. In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 are suppressed using values of "<10."

[48] The estimated number of people with SUD who can be served in an integrated care setting was obtained from Madras, Bertha K. et al. (2008). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. *Drug & Alcohol Dependence*, *99*(1), 280–295.

Because older adults often have more medical conditions, they may benefit from integrated health settings that can treat commonly co-occurring mental health and physical conditions.

Table 12: Prevalence of Substance Use Disorders (SUD) Among Adults in Nueces and Surrounding Counties (2017)[49,50]

Population	Nueces	Jim Wells	Kleberg	San Patricio
Total Population	**270,000**	**30,000**	**25,000**	**50,000**
Total Population in Poverty	90,000	15,000	10,000	15,000
Any Substance Use Disorder	**15,000**	**2,000**	**2,000**	**3,000**
SUD in Poverty[51]	9,000	1,000	1,000	2,000
Comorbid Psychiatric and SUD[52,53]	7,000	800	600	1,000
Needing but Not Receiving Treatment for Substance Use	15,000	2,000	1,000	3,000
Alcohol-Related SUD	**15,000**	**1,000**	**1,000**	**2,000**
Needing but Not Receiving Treatment for Alcohol Use	15,000	1,000	1,000	2,000
Illicit Drug-Related SUD	**6,000**	**700**	**500**	**1,000**
Needing but Not Receiving Treatment for Illicit Drug Use	5,000	600	500	1,000
Number of Drug-Related Deaths in 2017[54]	**77**	**<10**	**<10**	**<10**

[49] Unless otherwise specified, estimated prevalence of substance use disorders are based on prevalence rates drawn from the 2016–2017 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[50] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[51] The prevalence of any substance use disorder among adults and youth living in poverty is drawn from the national prevalence rate of alcohol or illicit drug dependence among those living at 199%, or less, of the federal poverty level according to results from the National Survey on Drug Use and Health, 2014.

[52] The local prevalence of co-occurring psychiatric and substance abuse disorders among adults are based on the intersection between the national prevalence rate of any mental illness and substance use disorder, as reported in SAMHSA's 2018 *Behavioral Health Trends in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53) report and the 2016–2017 National Survey on Drug Use and Health (NSDUH) rates of SMI for Texas.

[53] The local prevalence of comorbid psychiatric and substance use disorders among youth ages 12–17 is based on intersection between the national prevalence rate of major depressive episodes and SUD, as reported in SAMHSA's 2018 *Behavioral Health Trends in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53) report and the 2014–2016 National Survey on Drug Use and Health (NSDUH) sub-state rates of MDE for Texas.

[54] Death by drug overdose was data obtained from Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2017 on CDC WONDER Online Database. Accessed

Population	Nueces	Jim Wells	Kleberg	San Patricio
Number of Alcohol-Induced Deaths in 2017[55]	98	<10	<10	14

Local Mental Health Authority (LMHA) Utilization

The tables below draw from data received from the Texas Health and Human Services Commission (HHSC) in February 2018. HHSC provided data on children and adults served by LMHAs in fiscal year (FY) 2017. In tables 13 and 16, we provide estimates of the number of children, youth, and adults who need care, broken out by the ideal care setting.

Children and Youth

Table 13 below reports the total number of children and youth with any behavioral health need, with estimates of the number of children and youth who are best served in different care settings. The majority of youth with behavioral health needs can be met in an integrated care setting (15,000 of 25,000 total). About one in four children and youth need specialty care settings (6,000), including 3,000 with SED living in poverty who could benefit from care through the local mental health authority. Finally, about 2,000 (or 1 in 10) children and youth with behavioral health needs require rehabilitation or intensive care, including 300 with the most intensive needs who are at risk for out-of-home or out-of-school placement who require the most intensive services.

Table 13: Children and Youth in Need by Care Setting (2017)

Children and Youth – Community Care Need by Setting[56]	
Integrated Primary Care[57]	15,000
Specialty Behavioral Health Care[58]	6,000

at http://wonder.cdc.gov/mcd-icd10.html. Overdose deaths are classified using underlying cause-of-death ICD-10 codes: X40–44, X60–64, X85, and Y10–Y14.

[55] The number of alcohol-induced deaths were obtained from the Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2017 on CDC WONDER Online Database. Accessed at http://wonder.cdc.gov/mcd-icd10.html. Alcohol induced deaths are classified using any underlying cause of death and multiple causes of death category, "alcohol-induced causes." In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 are suppressed using values of "<10."

[56] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[57] MMHPI estimates that approximately 2 out of every 3 children (64%) with mental health needs have conditions that can be successfully managed in an integrated primary care setting.

[58] MMHPI estimates that 1 out of 4 children with mental health needs requires specialty behavioral health care to adequately manage their condition.

Children and Youth – Community Care Need by Setting[56]	
Children and Youth in Poverty Needing Specialty BH[59]	3,000
Mental Health Rehabilitation/Intensive Care[60]	**2,000**
Intensive Services[61]	300

Tables 14 and 15 provide an overview of the number of children and youth served by the local mental health authority – Behavioral Health Center of Nueces County, including breakouts for the number served at each level of care (LOC). In comparison to the 3,000 children and youth in poverty who need specialty care, as reported above, 715 children and youth received ongoing care through the LMHA. Additionally, of the approximately 2,000 needing rehabilitation and intensive services, 34 received YES waiver and six received intensive family services through the LMHA.

These estimates indicate a large gap in care for children and youth with serious emotional disturbances (SED) who are living in poverty. The largest need is for rehabilitation and intensive services, but many children and youth with SED are also not receiving ongoing specialty outpatient care. To close this gap, it is important to incorporate the previous population growth estimates. Table 3 includes a 9% estimated growth rate in the population of children and youth by 2025. Absent other factors, the number of children and youth with SED is likely to grow at this same rate.

[59] This estimate is developed using the prevalence of children and youth with serious emotional disturbance who are also living in poverty.

[60] MMHPI estimates that 1 in 10 children with mental health needs require mental health rehabilitation and/or intensive care to adequately manage their conditions.

[61] These are the children and youth with conditions that cause enough impairment that the they are at risk of out-of-home or out-of-school placement.

Table 14: Children and Youth with SED in Poverty Who Were Served by the LMHA (FY 2017)[62]

LMHA/Region	Total Child and Youth Population in Poverty[63]	Children and Youth with SED in Poverty[64]	Children and Youth Served in Ongoing Treatment[65]	Exact Percentage	Percentage Medicaid[66]
Behavioral Health Center of Nueces County	30,000	3,000	715	28%	91%

Table 15: Children and Youth Levels of Care Analysis (FY 2017)[67]

LMHA/ Region	Crisis Continuum		Ongoing TRR Treatment Levels				Specialized	
Levels of Care	Crisis	Transition	Medication Management	Targeted Services	Complex Services	Intensive Family	YES	Young Child
Behavioral Health Center of Nueces County	0	1	50	410	164	6	34	51
% by LOCs			7%	57%	23%	1%	5%	7%

Adults

As shown in Table 16 below, most adult mental health need can be adequately met in an integrated care setting (50,000 adults of the 65,000 with any mental health need). Of the remaining adults who need care in a specialty setting, we estimate that about 7,000 with serious mental illness who are living in poverty would benefit from care through the local mental health authority. In contrast, just 2,362 adults received ongoing care through the LMHA, representing 34% of estimated need. The estimated population of adults in Nueces is expected to grow by 10% by 2025. The number of adults in need of ongoing specialty care is likely to grow proportionately.

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[62] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column percentages or estimates may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[63] "In poverty" refers to the estimated number of people below 200% of the federal poverty level for the specified region.

[64] Local prevalence estimates of SED are drawn from Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Dallas, TX: Meadows Mental Health Policy Institute.

[65] Data in the "Children and Youth Served in Ongoing Treatment" column are the unduplicated number served by the LMHA across LOCs C1, C2, C3, and C4, as well as CY (YES Waiver) and CYC (Young Child Services).

[66] Percentage of children served by the LMHA who were receiving Medicaid during FY 2017. Data provided by DSHS (personal communication, February 26, 2018).

[67] Unduplicated utilization data across levels of care were obtained from Texas Health and Human Services Commission, February 2018, and reflect fiscal year 2017.

Table 16: Adults in Need, by Care Setting (2017)

Adults – Community Care Need by Setting[68]	
Adults with Mental Health Conditions[69]	**65,000**
Need That Can Be Met in Integrated Care[70]	**50,000**
Need That Requires Specialty Setting[71]	**10,000**
In Poverty Needing Specialty Care[72]	7,000
Complex Needs without Forensic Need (ACT)[73]	100
Complex Needs with Forensic Need (FACT)[74]	100
Adults with Substance Use Disorders[75]	**15,000**
Need That Can Be Met in Integrated Care[76]	**8,000**
Need That Requires Specialty Setting[77]	**9,000**

[68] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[69] Kessler, R. C., et al. (2012)a. Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 372–380, and Kessler, R. C., et al. (2012)b. Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 381–389.

[70] The estimated percentage of adults with any mental illness who can be served in integrated care was based on estimates of mild and moderate need, obtained from Kessler, R. C., et al. (2012)b. Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, *69*(4), 381–389.

[71] The remaining people with any mental health condition who need more intensive treatment than what can be provided in an integrated care setting (these people are categorized as needing specialty care).

[72] The estimated population of people with SMI living in poverty. Estimated local prevalence of SMI is drawn from Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Dallas, TX: Meadows Mental Health Policy Institute.

[73] Local prevalence estimates for the need for ACT are drawn from 12-month prevalence rates reported in Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*(12), 1803–1806.

[74] Local prevalence estimates for the need for FACT are drawn from 12-month prevalence rates reported in Cuddeback, G. S., Morrissey, J. P., & Cusack, K. J. (2008). How many forensic assertive community treatment teams do we need? *Psychiatric Services, 59*, 205–208.

[75] Unless otherwise specified, estimated prevalence of substance use disorders are based on prevalence rates drawn from 2016–2017 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[76] The estimated number of people with SUD who can be served in an integrated care setting was obtained from Madras, B. K. et al. (2008). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. *Drug & Alcohol Dependence*, *99*(1), 280–295.

[77] This category represents the remaining people with any SUD who need more intensive treatment than what can be provided in an integrated care setting (these people are categorized as needing specialty care).

Table 17: Number of Adults with SMI in Poverty Who Received Outpatient Services, by LMHA (FY 2017)[78]

Adults	Behavioral Health Center of Nueces County
SMI in Poverty[79,80]	7,000
All LOCs Served	2,362
% in Need Served	34%

Table 18: Adult Levels of Care Analysis (FY 2017)[81]

LMHA/ Region	Crisis Continuum		Ongoing Treatment Levels					
Levels of Care	Crisis Response	Crisis Transition	Medication Management	Skills Training	Medications & Therapy	Team Based	ACT	Total Non-Crisis
Behavioral Health Center of Nueces County	245	210	1	2,046	18	257	40	2,362
% by LOCs			0%	87%	1%	11%	2%	

The Emergency Department and Inpatient Crisis System

Access to high-quality community-based treatments for mental illness reduces the need for crisis services, including emergency department and inpatient psychiatric services. We were able to analyze utilization of services data for both of these settings based on discharge records we obtained from the Texas Health Care Information Collection (THCIC). THCIC comprises inpatient, emergency department, and outpatient discharge records for hospitals operating throughout Texas. Each discharge record included details on client age, length of stay, county of residence, charges (which reflect the nominal amount billed for each service), primary payer, and source of admission, among other variables.

[78] Utilization data were obtained from Texas Health and Human Services Commission, February 2018.

[79] Local prevalence estimates of SMI are drawn from Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Dallas, TX: Meadows Mental Health Policy Institute.

[80] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column percentages or estimates may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 are rounded to "<6," and estimated values between 5 and 9 are rounded to "<10."

[81] Unduplicated utilization data across levels of care were obtained from Texas Health and Human Services Commission, February 2018, and reflect fiscal year 2017.

We used these THCIC discharge records to analyze psychiatric inpatient and emergency department utilization in Nueces County, as depicted in the data tables below. Although we obtained data from 2015 through the fourth quarter of calendar year (CY) 2018, the data in the tables are limited to a single full year of data – January to December of 2018 – with the exception of the daily psychiatric versus inpatient capacity data, which show all utilization going back to January 2016. A description of this source is also included in Appendix 2. We anticipate updating these data in the full report.

Emergency Department Visits in Nueces County

Even in a community with an ideal array of integrated primary care, specialty care, and rehabilitation capacity, the emergency department (ED) will play an important role in helping with behavioral health crises. In systems without the full array of outpatient services, the ED takes on the less ideal and more frequent role of acting as the entry point to care for people with untreated behavioral health conditions.

This section provides an analysis of ED utilization resulting from primary psychiatric and substance use diagnoses. We also provide the primary payers and estimated payments associated with these visits.[82] This analysis can highlight sub-populations of adults who frequently utilize the ED, indicating a high need among a specific population or a lack of capacity to meet the needs of a specific population at lower levels of care. Of particular concern is the group of patients who either have Medicaid as their payer, pay for services themselves, rely on charity, or are uninsured. Admission of these patients in excessive numbers may reflect poor access to outpatient care by groups served by the public payers.

Because emergency departments are required to provide treatment, the characteristics of behavioral health patients seeking care at EDs are good indicators of those people in the community who experience behavioral health crises. We examine the distribution of ED patient's payer types, ages, and diagnoses, and contrast these with those of patients admitted to inpatient psychiatric facilities. This comparison and analysis will help us identify groups of patients in crisis who have limited access to inpatient beds.

There are 10 emergency departments that reported psychiatric and SUD-related emergency department visits to the THCIC: Bayview Behavioral Hospital, CHRISTUS Spohn – Corpus Christi, CHRISTUS Spohn Hospital – Corpus Christi Shoreline, CHRISTUS Spohn Corpus Christi – South, Corpus Christi Medical Center – Bay Area, Corpus Christi Medical Center – Doctors Regional, Corpus Christi Medical Center – Heart Hospital, Corpus Christi Medical Center – Northwest,

[82] Each discharge record includes information on the expected primary source of payment associated with the visit. We grouped these into one of five categories for the purposes of this analysis: Medicaid, Medicare, Other Governmental Payer, Self-Pay, and Commercial Insurance.

Driscoll Children's Hospital, and South Texas Surgical Center. Corpus Christi Medical Center – Heart Hospital and South Texas Surgical Hospital each reported fewer than 10 psychiatric or SUD ED visits. Because of the small number of total visits, these EDs were included in total counts but not as separate breakouts in Table 19 below.

As Table 19 shows, CHRISTUS Spohn Hospital – Corpus Christi was the most frequently utilized ED for psychiatric visits (2,066 of 6,588 visits), but Corpus Christi Medical Center – Bay Area was more frequently utilized for ED visits related to SUD diagnoses (306 of 1,230 visits), based on data from 2018. For psychiatric ED visits, Bayview Behavioral Hospital and CHRISTUS Spohn Hospital Corpus Christi – Shoreline were also frequently used, but combined total visits for both (1,851) were still fewer than the count of visits to CHRISTUS Spohn – Corpus Christi. Aside from the Heart Hospital and South Texas Surgical Hospital, Corpus Christi Medical Center – Northwest had the fewest psychiatric ED visits, whereas Driscoll Children's Hospital had the fewest SUD-related ED visits. Across all EDs, there were more than five times as many ED visits for primary psychiatric conditions than there were for substance use conditions. This ratio is consistent with the prevalence data presented in tables 15 and 16, suggesting that mental health conditions are nearly five times as prevalent as substance use disorders in Nueces County.

Some differences in the proportion of primary payers types listed for each hospital are notable. These are based on each discharge record's primary payer source, as reported by the hospital. Because in past systems assessments we have encountered some mis-coding of payer type on discharge records, we encourage hospitals to confirm these results. Table 19 shows that, overall, people visiting EDs for psychiatric disorders are more likely to be funded through Medicaid (30%) or Medicare (21%) than are people visiting for SUD (22% Medicaid, 13% Medicare). Emergency department visits for substance use disorders are more likely to be self-funded (47%) than are visits for psychiatric conditions (27%). This contrast was most apparent at Corpus Christi Medical Center – Northwest, where 60% of SUD-related ED visits were self-funded in comparison to 35% of psychiatric ED visits being self-funded.

Across all hospitals, SUD-related ED visits and psychiatric-related ED visits were funded through commercial insurance in approximately equal proportions. However, at Bayview Behavioral Hospital, SUD-related visits were more often funded through commercial insurance (25%) than were psychiatric-related ED visits (17%). At CHRISTUS Spohn – Corpus Christi, the reverse was true: 19% of psychiatric-related visits were funded through commercial insurance compared to only 11% of SUD-related ED visits. CHRISTUS Spohn – Corpus Christi has the largest proportion of self-pay behavioral health patients (31% of psychiatric visits and 52% of SUD visits) and may experience financial challenges serving this group of patients.

Table 19: Emergency Department Inpatient and Outpatient Psychiatric Visits, by Visit Type and Payer – All Ages (CY 2018)

Hospital	Total Number of ED Visits[83]	Payer Percentage[84]				
		Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Bayview Behavioral Hospital						
Psychiatric Diagnoses	929	29%	20%	11%	21%	17%
Substance Use Diagnoses	64	14%	19%	2%	38%	25%
CHRISTUS Spohn – Corpus Christi						
Psychiatric Diagnoses	2,066	27%	21%	3%	31%	19%
Substance Use Diagnoses	130	28%	6%	2%	52%	11%
CHRISTUS Spohn Hospital Corpus Christi – Shoreline						
Psychiatric Diagnoses	922	32%	22%	2%	31%	13%
Substance Use Diagnoses	278	28%	10%	3%	43%	15%
CHRISTUS Spohn Hospital Corpus Christi – South						
Psychiatric Diagnoses	584	29%	15%	4%	26%	26%
Substance Use Diagnoses	107	24%	7%	5%	38%	25%
Corpus Christi Medical Center – Bay Area						
Psychiatric Diagnoses	646	19%	27%	3%	30%	19%
Substance Use Diagnoses	306	14%	15%	1%	49%	21%
Corpus Christi Medical Center – Doctors Regional						
Psychiatric Diagnoses	553	21%	36%	3%	27%	12%
Substance Use Diagnoses	174	20%	23%	1%	50%	6%
Corpus Christi Medical Center – Northwest						
Psychiatric Diagnoses	399	21%	25%	1%	35%	18%
Substance Use Diagnoses	128	17%	10%	1%	60%	9%
Driscoll Children's Hospital						
Psychiatric Diagnoses	477	70%	0%	2%	6%	22%
Substance Use Diagnoses	36	61%	0%	0%	17%	22%
All Psychiatric ED Visits	**6,588**	**30%**	**21%**	**4%**	**27%**	**18%**
All Substance Use ED Visits	**1,230**	**22%**	**13%**	**2%**	**47%**	**16%**

[83] Hospitals with a handful of behavioral health visits are not included. These hospitals were South Texas Surgical Hospital (five visits), and Corpus Christi Medical Center – Heart Hospital (14 visits).

[84] Forty-two (42) visits to EDs in Nueces County had an unknown payer.

Suicide-Related ED Visits / Co-Occurring and SUD-Related ED Visits

As reported in Table 20, nearly 800 suicide-related ED visits occurred between January and December 2018, representing about 10% of all behavioral health ED visits. Most of these (424) were among adults between the ages of 18 and 64, followed by youth (298) between the ages of 12 and 17. Older adults and children had smaller counts of suicide-related ED visits (fewer than 20 among each age group).

Applying national rates to the Nueces County population, we estimate 3,000 youth engage in self-harm behavior. As such, about 10% of youth who engaged in self-harm behavior end up in the ED. Fewer than 10 youth completed suicide in 2017, which is less than 4% of the number of suicide-related ED visits for youth. Our estimate of self-harm is based on applying a national rate; however, the ED data represent counts of actual events. As such, we recommend monitoring the frequency of youth and adult suicide-related ED visits as a metric for evaluating the severity of self-harm behavior in Nueces County as well as an outcome measure for any suicide prevention programs.

Forty-eight adults completed suicide in Nueces County in 2017, which accounts for over 11% of the 2018 adult suicide-related ED visits. Among adults with suicide-related ED visits, 20% also had an SUD diagnosis (compared to 11% of older adults and 12% of youth). The frequency of suicide-related ED visits for people with substance used disorders suggests a potential gap in care for SUD treatment programs.

Forty-six percent of adults visiting CHRISTUS Spohn – Corpus Christi and 28% of adults visiting Driscoll Children's Hospital had an SUD diagnosis, compared to just 9% at Corpus Christi Medical Center – Doctors Regional and 8% at CHRISTUS Spohn Corpus Christi – South.

Table 20: Suicide and Substance-Related Emergency Department Visits by Age (CY 2018)

Population	Suicide-Related Visits	% with SUD Diagnosis
Adults (Age 18 to 64)	**424**	**20%**
CHRISTUS Spohn – Corpus Christi	79	46%
CHRISTUS Spohn Hospital Corpus Christi – Shoreline	197	14%
CHRISTUS Spohn Hospital Corpus Christi – South	36	8%
Driscoll Children's Hospital	16	38%
Corpus Christi Medical Center – Bay Area	47	21%
Corpus Christi Medical Center – Doctors Regional	34	9%
Corpus Christi Medical Center – Heart Hospital	1	0%
Corpus Christi Medical Center – Northwest	14	0%

Population	Suicide-Related Visits	% with SUD Diagnosis
Older Adults (Age 65 and Older)	**19**	**11%**
CHRISTUS Spohn – Corpus Christi	4	25%
CHRISTUS Spohn Hospital Corpus Christi – Shoreline	10	10%
CHRISTUS Spohn Hospital Corpus Christi – South	4	0%
Corpus Christi Medical Center – Bay Area	1	0%
Youth (Age 12 to 17)	**298**	**12%**
CHRISTUS Spohn – Corpus Christi	2	0%
CHRISTUS Spohn Hospital Corpus Christi – Shoreline	11	0%
CHRISTUS Spohn Hospital Corpus Christi – South	13	0%
Driscoll Children's Hospital	251	14%
Corpus Christi Medical Center – Bay Area	14	7%
Corpus Christi Medical Center-Doctors – Regional	4	0%
Corpus Christi Medical Center – Northwest	3	0%
Children (Age 0 to 11)	**18**	**0%**
Driscoll Children's Hospital	18	0%
Total ED Visits	**759**	**16%**

Table 21 reports ED visits for primary psychiatric or substance use diagnoses (separately), with sub-breakouts of secondary SUD or psychiatric diagnoses. Among those people with primary psychiatric diagnoses who visited the ED, about 25% (1,679) had a secondary SUD diagnosis. Among those with primary SUD ED visits, 419 (34%) had a secondary psychiatric diagnosis. These high rates of ED visits for co-occurring psychiatric and substance use disorders highlight the need for outpatient treatment programs that integrate treatment for co-occurring disorders.

In a later section, Table 32 reports inpatient visits for primary psychiatric or substance use diagnosis. When contrasted to Table 32, Table 21 shows that people visiting the ED for primary SUD diagnoses have secondary psychiatric diagnoses at lower frequencies than people receiving inpatient psychiatric care for primary SUD. This finding is consistent with hospitalizing only those people with more severe conditions, such as co-occurring psychiatric and SUD. It also emphasizes that people with multiple, complex needs will have high rates of both ED and inpatient use if they are not treated successfully in the community.

Table 21: Nueces Emergency Department (ED) Visits with Co-Occurring Psychiatric and Substance Use Disorders – All Ages (CY 2018)

Hospital of Admission	Primary Psychiatric Diagnosis		Primary Substance Use Diagnosis	
	ED Visits	Visits with Secondary SUD Diagnoses	ED Visits	Visits with Secondary Psychiatric Diagnoses
All Admissions to Local EDs	**6,588**	**1,679**	**1,230**	**419**
CHRISTUS Spohn – Corpus Christi	2,066	887	130	69
CHRISTUS Spohn Hospital Corpus Christi – Shoreline	922	140	278	95
CHRISTUS Spohn Hospital Corpus Christi – South	584	36	107	30
Driscoll Children's Hospital	477	45	36	18
Corpus Christi Medical Center – Bay Area	646	81	306	75
Corpus Christi Medical Center – Doctors Regional	553	61	174	49
Corpus Christi Medical Center – Heart Hospital	9	2	5	3
Bayview Behavioral Hospital	929	399	64	54
Corpus Christi Medical Center – Northwest	399	28	128	26
South Texas Surgical Hospital	3	N/A	2	N/A

Co-Morbid Health Conditions and Emergency Department Visits

Some primary physical health conditions result in ED visits more often when a person has secondary psychiatric or substance use disorders. Table 22 below reports the top physical health ED visits among people with secondary behavioral health disorders. Pain in the throat/chest was the most common primary physical condition among people with secondary psychiatric, SUD, and co-occurring psychiatric and substance use disorders (COPSD). Abdominal pain and sepsis were also frequent across all categories. However, among people with secondary SUD diagnoses, but not among those with secondary psychiatric diagnoses, alcoholic liver disease, nausea and vomiting, open head wounds, and heart attacks were in the top 10 primary physical health conditions leading to ED visits. People with secondary psychiatric diagnoses frequented the ED for COPD, type 2 diabetes, urinary disorder, and headaches more often than people with SUD. People with secondary COPSD frequented the ED for acute pancreatitis, epilepsy, and skull or facial fractures more often than those with secondary psychiatric or SUD alone.

Many of these comorbid medical conditions, such as chronic pain, sepsis, and diabetes, reflect conditions best treated in integrated primary care or specialty care settings. The high levels of people with behavioral health conditions visiting the ED for these comorbid medical conditions may reflect a lack of access to integrated primary and behavioral care. The data in Table 22

provide a magnitude of the potentially avoidable ED visits in Nueces County with the implementation of integrated care.

Table 22: Medical Emergency Department (ED Visits) in Nueces County with Co-Occurring Psychiatric and Substance Use Disorders (COPSD) – All Ages (CY 2018)

Rank	Primary Physical Health Diagnoses with the Most Secondary Psychiatric Diagnoses		Primary Physical Health Diagnoses with the Most Secondary SUD Diagnoses		Primary Physical Health Diagnoses with the Most COPSD Diagnoses	
	Top Physical Health Diagnoses	Visits	Top Physical Health Diagnoses	Visits	Top Physical Health Diagnoses	Visits
1	Throat/Chest Pain	1,171	Throat/Chest Pain	250	Throat/Chest Pain	97
2	Abdominal/Pelvic Pain	820	Other Sepsis	164	Abdominal/Pelvic Pain	69
3	Dorsalgia	441	Abdominal/Pelvic Pain	124	Other Sepsis	45
4	Other Sepsis	386	Cellulitis/Acute Lymphangitis	123	Cellulitis/Acute Lymphangitis	33
5	Other Disorders of the Urinary System	314	Cutaneous Abscess	97	Cutaneous Abscess	33
6	Other COPD	263	Nausea/Vomiting	81	Epilepsy/Seizures	26
7	Other Joint Disorder	257	Alcoholic Liver Disease	81	Acute Pancreatitis	24
8	Headache	253	Open Head Wound	77	Skull/Facial Fracture	22
9	Cellulitis/Acute Lymphangitis	234	Acute Pancreatitis	69	Narcotics and Psychodysleptics	22
10	Type 2 Diabetes	234	Heart Attack	69	Open Head Wound	21

Inpatient Admissions from Nueces County Emergency Departments

Inpatient hospitalization is best provided in a patient's local community. Local care improves access for the patient's family and support group and helps the patient integrate back into the community and engage with community-based services. In the next set of maps and data tables, we focus on admissions from Nueces County emergency departments (ED) to an inpatient psychiatric bed anywhere in Texas, showing how patients are separated from their communities to receive inpatient care. We identify these types of admissions by determining, for every psychiatric bed admission, whether a patient had been in a Nueces County ED on the same or previous day. County of residence of the patient did not play a role in this analysis.

There are reasons for large geographic separations between EDs and inpatient facilities, including behavioral health crises that occur during travel and the provision of specialized inpatient behavioral treatment such as competency restoration at a state hospital. Geographic gaps of concern are those that only occur for specific payers (such as sending self-pay patients to distant hospitals) or specific age groups (no youth beds), or because of insufficient local beds in total.

Map 6 and Table 23, below, show the number of patients sent from these EDs to psychiatric beds across Texas. Table 24 provides payer details. Figure 1 and Table 25 reports the lengths of stay among people receiving inpatient care from a Nueces County ED. Of 418 admissions to psychiatric hospitals from Nueces County EDs, most (245, 59%) were sent to local Nueces County beds, whereas 173 (41%) were sent to hospitals in other counties.

Most hospitals in other counties that patients from Nueces County EDs were specialized behavioral health facilities. With the exception of Palms Behavioral Health in Cameron County, no single facility took a significant number of patients from Nueces County EDs, which might occur if a multilocation hospital system sent all behavioral health patients to a single location. A similar proportion of adults and youth were sent to out-of-county psychiatric beds, indicating that neither type of local bed was disproportionately available to local EDs.

Map 6: Admissions to Psychiatric Hospitals from Nueces County Emergency Departments – All Ages (CY 2018)

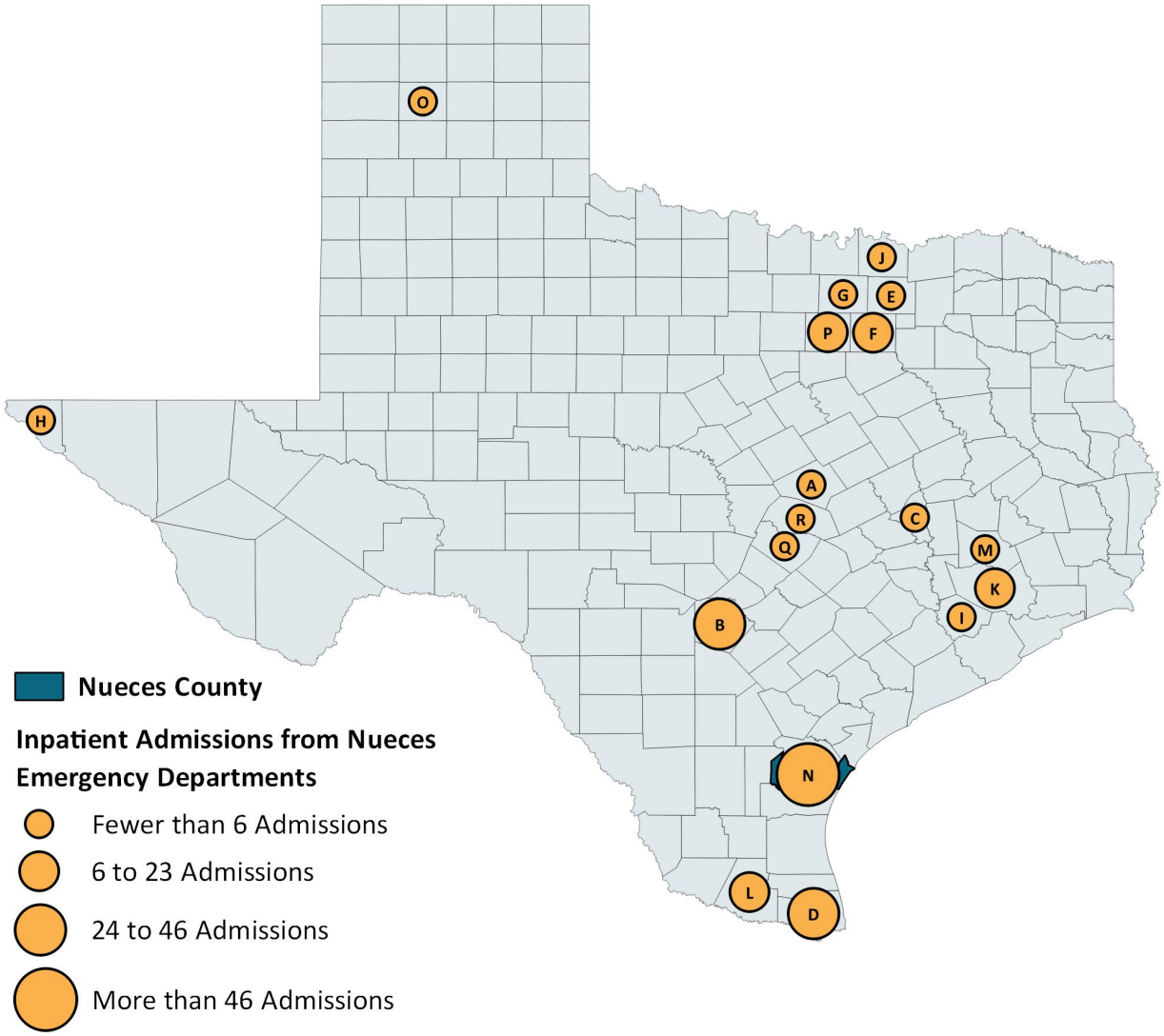


Table 23: Admissions to Psychiatric Hospitals from Nueces County Emergency Departments, by Age (CY 2018)

Map Label	County and Hospital of Admission	Total Admissions	Adults (Age 18 to 64)	Older Adults (Age 65 and Older)	Youth (Age 12 to 17)
A	**Bell**	**2**	**1**	**N/A**	**1**
	Cedar Crest Hospital	1	N/A	N/A	1
	Scott & White Medical Center Temple	1	1	N/A	N/A
B	**Bexar**	**44**	**31**	**2**	**7**
	Clarity Child Guidance Center	4	N/A	N/A	3

Map Label	County and Hospital of Admission	Total Admissions	Adults (Age 18 to 64)	Older Adults (Age 65 and Older)	Youth (Age 12 to 17)
	Laurel Ridge Treatment Center	20	14	N/A	3
	Methodist Specialty & Transplant Hospital	11	11	N/A	N/A
	Nix Behavioral Health Center	1	1	N/A	N/A
	Nix Health Care System	4	2	2	
	Nix Specialty Health Center	1	1	N/A	N/A
	San Antonio Behavioral Healthcare Hospital	3	2	N/A	1
C	**Brazos – Rock Prairie Behavioral Health**	**3**	**1**	**N/A**	**2**
D	**Cameron – Palms Behavioral Health**	**46**	**30**	**4**	**12**
E	**Collin**	**3**	**2**	**N/A**	**1**
	Columbia Medical Center-McKinney	1	1	N/A	N/A
	Texas Health Seay Behavioral Health Center	2	1	N/A	1
F	**Dallas**	**11**	**5**	**N/A**	**5**
	Dallas Behavioral Healthcare Hospital	4	1	N/A	2
	Green Oaks Hospital	2	N/A	N/A	2
	Methodist Richardson Medical Center	2	2	N/A	
	Sundance Hospital Dallas	3	2	N/A	1
G	**Denton – University Behavioral Health-Denton**	**2**	**1**	**N/A**	**1**
H	**El Paso – El Paso Behavioral Health System**	**3**	**N/A**	**N/A**	**2**
I	**Fort Bend – Westpark Springs**	**2**	**N/A**	**N/A**	**2**
J	**Grayson – Texoma Medical Center**	**3**	**2**	**N/A**	**1**
K	**Harris**	**11**	**2**	**2**	**6**
	Behavioral Hospital – Bellaire	2	N/A	N/A	2
	Cypress Creek Hospital	1	N/A	N/A	1
	Houston Behavioral Healthcare Hospital	1	N/A	N/A	1
	Kingwood Pines Hospital	1	N/A	N/A	
	Oceans Behavioral Hospital of Katy	2	N/A	2	N/A
	St Joseph Medical Center	1	1	N/A	

Map Label	County and Hospital of Admission	Total Admissions	Adults (Age 18 to 64)	Older Adults (Age 65 and Older)	Youth (Age 12 to 17)
	Sun Behavioral Houston	2	1	N/A	1
	West Oaks Hospital	1	N/A	N/A	1
L	**Hidalgo – McAllen Medical Center**	**23**	**15**	**1**	**5**
M	**Montgomery – Aspire Hospital**	**1**	**1**	**N/A**	**N/A**
N	**Nueces**	**245**	**140**	**18**	**81**
	Bayview Behavioral Hospital	131	42	2	81
	CHRISTUS Spohn – Corpus Christi	114	98	16	N/A
O	**Potter – Northwest Texas Hospital**	**1**	**1**	**N/A**	**N/A**
P	**Tarrant**	**10**	**4**	**N/A**	**6**
	John Peter Smith Hospital	1	1	N/A	N/A
	Mesa Springs	2	N/A	N/A	2
	Millwood Hospital	4	N/A	N/A	4
	Texas Health Arlington Memorial Hospital	2	2	N/A	N/A
	Texas Health Springwood Hospital	1	1	N/A	N/A
Q	**Travis**	**5**	**4**	**N/A**	**1**
	Austin Lakes Hospital	1	1	N/A	N/A
	Austin Oaks Hospital	1	1	N/A	N/A
	Seton Shoal Creek Hospital	2	1	N/A	1
	Texas NeuroRehab Center	1	1	N/A	N/A
R	**Williamson – Georgetown Behavioral Health Institute**	**3**	**1**	**N/A**	**2**
Total Admissions		**418**	**241**	**27**	**135**
Total Admissions to Nueces Hospitals		**245**	**140**	**18**	**81**
Total Admissions to Non-Local Hospitals		**173**	**101**	**9**	**54**

Table 24 shows the primary payer associated with psychiatric hospitalizations from Nueces County EDs, with breakouts showing local versus non-local psychiatric hospitals. People who were sent to hospitals from Nueces County EDs were sent to non-local beds more often if they were funded through commercial insurance, as compared to patients sent to local hospitals. This variation reflects the larger range of hospital choices available to patients with commercial patients, but it does not necessarily reflect reduced access to quality care for other payer types.

In contrast, people who are self-funded or funded through Medicaid were generally more often sent to local psychiatric hospitals. As shown in Table 29, this trend was also generally true among people admitted to local psychiatric hospitals as compared to people sent to non-local hospitals; patients were usually funded through Medicaid and self-pay if they were sent to local hospitals. However, this pattern does not hold for every hospital. For example, at Corpus Christi Medical Center – Northwest, no self-funded patients were sent to local beds. This pattern of sending self-funded patients from this ED to more distant inpatient facilities may reflect a problem between the ED and the local hospitals providing charity care.

As reported in Table 24, below, 13% of people who were admitted to a psychiatric bed from a Nueces County ED were self-funded, 21% were funded through Medicare, and about 33% were funded through commercial insurance. In contrast, among all psychiatric ED visits as reported in Table 19, a higher proportion of people were self-funded (27%) or had Medicare (21%), and only 18% were funded through commercial insurance. People who were self-funded or funded through Medicare appeared less likely to receive inpatient care after visiting an ED, whereas people with commercial insurance were more likely to receive care. This pattern suggests a lack of access for self-pay and Medicaid patients.

Table 24: Admissions to Psychiatric Hospitals from Nueces Emergency Departments, All Ages by Payer (CY 2018)

Admissions from Nueces EDs to Psychiatric Beds[85]	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Total Admissions from Nueces EDs	**418**	**32%**	**13%**	**8%**	**13%**	**33%**
to Non-Local Psychiatric Bed	173	23%	15%	5%	6%	50%
to Local Psychiatric Bed	245	38%	12%	10%	18%	21%
CHRISTUS Spohn – Corpus Christi ED						
to Non-Local Psychiatric Bed	11	9%	27%	9%	0%	55%
to Local Psychiatric Bed	15	20%	27%	0%	27%	27%
CHRISTUS Spohn Hospital Corpus Christi – Shoreline ED						
to Non-Local Psychiatric Bed	12	25%	17%	0%	8%	50%
to Local Psychiatric Bed	79	29%	15%	9%	28%	19%

[85] EDs with fewer than 10 visits resulting in a psychiatric inpatient admission were included in the count of "all admissions," but were not included in ED-specific breakouts. These included Bayview Behavioral Hospital ED (seven visits) and Corpus Christi Medical Center – Heart Hospital ED (two visits).

Admissions from Nueces EDs to Psychiatric Beds[85]	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
CHRISTUS Spohn Hospital Corpus Christi – South ED						
to Non-Local Psychiatric Bed	9	11%	33%	11%	0%	44%
to Local Psychiatric Bed	22	23%	23%	5%	23%	27%
Corpus Christi Medical Center – Bay Area ED						
to Non-Local Psychiatric Bed	43	14%	12%	0%	14%	58%
to Local Psychiatric Bed	17	18%	35%	6%	24%	18%
Corpus Christi Medical Center – Doctors Regional ED						
to Non-Local Psychiatric Bed	31	19%	29%	3%	3%	45%
to Local Psychiatric Bed	24	4%	4%	67%	21%	0%
Corpus Christi Medical Center – Northwest ED						
to Non-Local Psychiatric Bed	21	24%	19%	10%	10%	38%
to Local Psychiatric Bed	4	25%	25%	0%	0%	50%
Driscoll Children's Hospital ED						
to Non-Local Psychiatric Bed	39	33%	0%	8%	3%	56%
to Local Psychiatric Bed	82	70%	0%	0%	5%	26%

Furthermore, our comparison of length of stay between patients sent by EDs to local versus non-local inpatient facilities revealed notable differences. As shown in Figure 1 and Table 25, people who were sent from Nueces County EDs to psychiatric beds averaged longer lengths of stay (four to nine days) when they were sent to non-local hospitals, compared to patients sent to local hospitals, who usually had lengths of stay of less than one week. Longer lengths of stay for patients who are sent to distant hospitals exacerbate problems in involving family and other supports in treatment. In the case of some admissions, this may be an unfortunate but necessary consequence of needing highly specialized services and facilities such as state hospital admissions for competency restoration. But it may also reflect a lack of local skilled nursing facilities, forcing patients needing longer periods of care to be sent far from their natural supports.

Figure 1: Admissions to Psychiatric Beds from all Nueces EDs – Length of Stay Details (CY 2018)

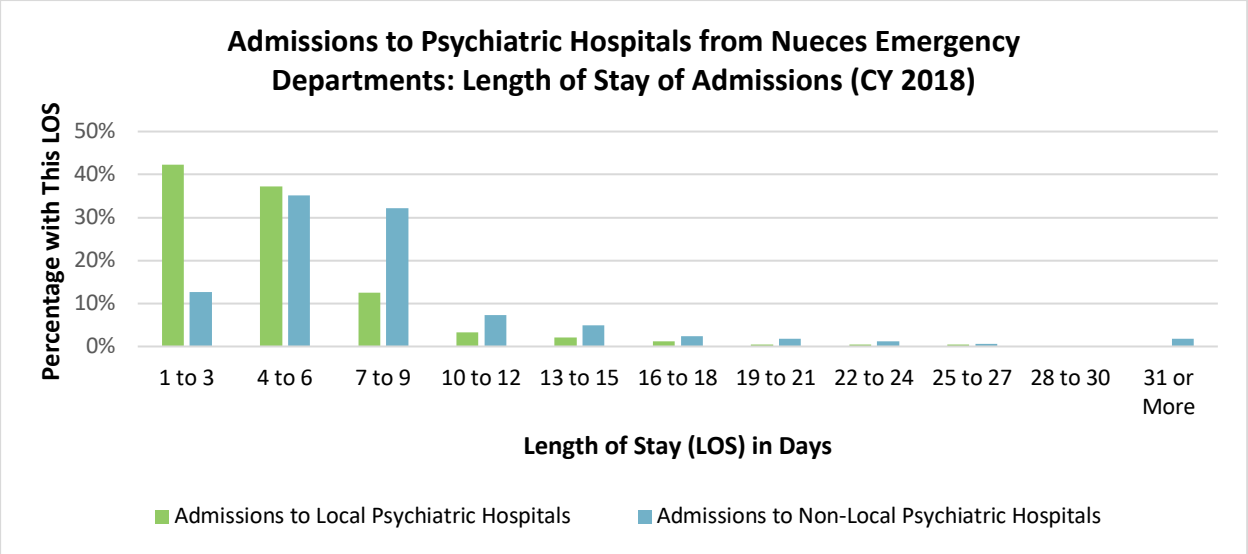


Table 25: Data Associated with Figure 1 (Length of Stay of Admissions from Nueces EDs to Psychiatric Beds) (CY 2018)

Admissions from Nueces EDs to Psychiatric Beds				
Length of Stay in Days	**Total Admissions from Nueces EDs**	**Percentage Admitted to Local Hospitals**	**Percentage Admitted to Non-Local Hospitals**	**Percentage Admitted to All Hospitals**
1 to 3 Days	122	42%	13%	30%
4 to 6 Days	147	37%	35%	36%
7 to 9 Days	83	13%	32%	21%
10 to 12 Days	20	3%	7%	5%
13 to 15 Days	13	2%	5%	3%
16 to 18 Days	7	1%	2%	2%
19 to 21 Days	4	<1%	2%	1%
22 to 24 Days	3	<1%	1%	1%
25 to 27 Days	2	<1%	1%	<1%
28 to 30 Days	N/A	N/A	N/A	N/A
31 to 60 Days	3	<1%	2%	1%

In summary, examining the flow of patients from local EDs to inpatient psychiatric beds statewide revealed anticipated patterns. These patterns included most patients being sent to local beds and some patients being admitted to non-local hospital beds as a result of

idiosyncratic patient characteristics, such as people experiencing a behavioral health crisis while traveling. However, we did identify several potential issues of concern:

- Palms Behavioral Health in Cameron County received several patients from local EDs. Given Palms Behavioral Health's distance from Nueces County, further investigation is warranted to determine whether these patients would be better served locally.
- Corpus Christi Medical Center – Northwest did not send any self-funded patients to local inpatient hospitals. This hospital had a small number of admissions to inpatient beds anywhere, which may explain this pattern.
- As compared to all ED behavioral health visits, self-funded patients were less likely to be admitted to a psychiatric bed. This variance likely reflects reduced bed availability for patients without a payer.

Psychiatric Bed Capacity and Utilization

In the previous section, we examined the flow of patients from local EDs to inpatient beds. We now analyze inpatient bed use by all Nueces County residents as well as the bed capacity and use of Nueces County inpatient psychiatric beds by residents of all counties. Our analysis focuses on two issues: identifying whether sufficient beds exist locally to serve all the needs of Nueces County residents and assessing the impact that insufficient community-based outpatient services capacity has on bed use. Please see Appendix 2 for a description of the sources we used for this analysis.

Nueces County Psychiatric Hospital Utilization

Two hospitals in Nueces County reported inpatient psychiatric utilization: Bayview Behavioral Hospital and CHRISTUS Spohn – Corpus Christi. In our community assessments we are often asked whether a community has sufficient inpatient capacity. There is no formula that can simply address this question and answering it depends on multiple factors (service array, existing capacity). The next section takes three approaches to assess this capacity question. The first approach, as presented in Table 26, subdivides patients admitted to psychiatric beds by payer type and age group. Disproportionate use of beds by patients with commercial insurance may indicate a lack of access for self-pay or lower paying Medicaid patients. Excessive bed use by self-pay or Medicaid patients may indicate that local hospitals my have potential financing challenges for psychiatric beds.

The second approach, presented in Table 27, analyzes the county of residence of patients admitted to psychiatric beds in Nueces County. This analysis can highlight another facet of bed capacity: many patients residing in distant counties likely use Nueces County psychiatric beds because the county has available beds. In a related analysis, we examine the use of non-Nueces psychiatric beds by residents of Nueces County. If the flow of patients out of the county is substantially greater than the flow in, there may be a lack of local beds.

Finally, we use Table 30 and figures 2–5 to compare, for each hospital, daily inpatient utilization relative to reported staffed bed capacity. This approach may identify hospitals that are operating beyond capacity or under capacity relative to need. Prolonged operation at or above capacity may indicate insufficient capacity to meet need. Additionally, the time series graphs (figures 2–5) are useful for identifying whether periods at full capacity are only seasonal or reflect long-term trends.

Table 26 shows admissions to Nueces County psychiatric beds, by age group and by payer. In aggregate across the two hospitals, the predominant payer for older adults was Medicare, whereas for children and youth, it was Medicaid. Adults have a broader range of payers, with a significant portion categorized as self-pay. In many cases, "self-pay" corresponds to adults in poverty who had no way to pay for hospitalization.

Among the hospitals, a higher proportion of admissions to CHRISTUS Spohn – Corpus Christi were self-pay (28%) or paid by commercial insurance (24%), compared to 16% of admissions to Bayview Behavioral Hospital that were self-pay and 19% paid for by commercial insurance. More adults visit CHRISTUS Spohn – Corpus Christi than visit Bayview Behavioral Hospital. But, among both adults and older adults, a slightly higher percentage of patients at Bayview Behavioral Hospital were paid for by Medicare (18% adults, 90% older adults), compared to 14% of adults and 86% of older adults admitted to CHRISTUS Spohn – Corpus Christi. Although CHRISTUS Spohn – Corpus Christi does not admit children, most patients admitted to Bayview Behavioral Hospital were paid for by Medicaid. The higher reimbursement rates from commercial insurance and Medicare (both disproportionately at Christus Spohn) likely offset the corresponding lower rate from self-pay patients.

Below, we contrast the distribution of payer types of people admitted to local hospital inpatient beds versus those served in the ED with a mental health or SUD condition. Table 19, above, showed that, in aggregate across area EDs, 27% of psychiatric ED visits and 47% of SUD ED visits were categorized as self-pay. This ratio contrasts with the 16% of inpatient bed patients at Bayview Behavioral Hospital and 28% of inpatient bed patients at Christus Spohn – Corpus Christi. Focusing on the 27% of self-pay ED psychiatric patients, Christus Spohn – Corpus Christi admitted a slightly larger share (28%) of self-pay psychiatric bed patients, indicating that there was no barrier to accessing care by this payer type. Bayview Behavioral Hospital, with 16% of inpatient psychiatric admissions by self-pay patients, may be less accessible to self-pay ED patients than to other payer types.

Table 26: Admissions by Age Group and Payer to Psychiatric Beds at Nueces County Hospitals (CY 2018)[86]

Age Group	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Bayview Behavioral Hospital						
All Ages	**2,388**	**41%**	**13%**	**9%**	**16%**	**19%**
Adults (Age 18 to 64)	1,336	22%	18%	13%	25%	21%
Older Adults (Age 65 and older)	83	4%	90%	0%	0%	5%
Youth (Age 12 to 17)	906	71%	0%	4%	4%	20%
Children (Age 6 to 11)	63	78%	2%	10%	3%	8%
CHRISTUS Spohn – Corpus Christi						
All Ages	**1,680**	**22%**	**22%**	**4%**	**28%**	**24%**
Adults (Age 18 to 64)	1,495	25%	14%	4%	32%	26%
Older Adults (Age 65 and older)	185	1%	86%	3%	0%	10%

Table 27 lists admissions to each hospital by county of residence (residents of Nueces County compared to all other non-local counties). At both hospitals (Bayview Behavioral Hospital and CHRISTUS Spohn – Corpus Christi), the majority of admissions were for local residents, with approximately 25% of admissions for non-local residents. Bayview Behavioral Hospital's non-local patients matched the local patients in payer type, with the exception of self-funded patients (10% versus 19%) and patients with other government payer type (22% versus 2%).

Similarly, people admitted to CHRISTUS Spohn – Corpus Christi were more likely to be self-funded if they were a local resident (29% of admissions by local residents) compared to those who were admitted from outside counties (18%). Thirty-eight percent (38%) of non-local residents admitted to CHRISTUS Spohn – Corpus Christi were funded through Medicare compared to 20% of admissions of Nueces County residents. Overall, among all admissions, regardless of county of residency, people admitted to CHRISTUS Spohn – Corpus Christi were more likely to be self-funded or funded through commercial insurance, whereas people admitted to Bayview Behavioral Hospital were more likely to be funded through other governmental payers. Bayview Behavioral Hospital also had higher proportions of Medicaid funding and lower proportions of Medicare funding. This difference is likely a result of Bayview

[86] Percentages in rows may not add up to 100% because a small number of admissions (fewer than 1%) did not have an identified payer. The table does not include hospitals with fewer than 10 admissions in the reported period. These include 30 total admissions across CHRISTUS Spohn Corpus Christi – Shoreline, Corpus Christi Medical Center – Bay Area, Corpus Christi Medical Center – Doctors Regional, and Corpus Christi Medical Center – Northwest.

Behavioral Hospital admitting children and youth, whereas CHRISTUS Spohn – Corpus Christi only admits adults.

Table 27: Admissions to Nueces Psychiatric Beds by Local Versus Non-Local Residents (CY 2018)[87]

Hospital	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Bayview Behavioral Hospital						
Total Admissions	**2,388**	**41%**	**13%**	**9%**	**16%**	**19%**
Admissions by Nueces Residents	1,538	44%	14%	2%	19%	19%
Non-Local Admissions	850	36%	11%	22%	10%	20%
CHRISTUS Spohn – Corpus Christi						
Total Admissions	**1,680**	**22%**	**22%**	**4%**	**28%**	**24%**
Admissions by Nueces Residents	1,491	23%	20%	3%	29%	24%
Non-Local Admissions	189	13%	38%	7%	18%	24%

Kleberg, Jim Wells, and San Patricio County Psychiatric Hospitals

From 2015 through 2018, two hospitals in the counties surrounding Nueces County had psychiatric bed utilization: CHRISTUS Spohn Hospital – Alice in Jim Wells County and Care Regional Medical Center in San Patricio County. Care Regional Medical Center had 12 psychiatric beds for adults, but it closed in September 2017 after Hurricane Harvey. CHRISTUS Spohn Hospital – Alice had 11 psychiatric beds available to adults, but utilization ended in mid-August 2017. Both hospitals had at least one bed available on any given day from 2015 until each closed in 2017. The closure of these nearby hospitals may be one reason for the apparent increase in daily utilization at Bayview Behavioral Hospital in 2017 and 2018.

Nueces County Residents: Psychiatric Bed Utilization Statewide (CY 2018)

This next section shows where residents of Nueces County (identified in dark blue on Map 7) were admitted to psychiatric beds throughout Texas. This analysis can provide additional context for psychiatric bed need in Nueces County. Frequent use of psychiatric beds outside of the region may indicate insufficient local capacity to serve local residents. Additional breakouts showing admissions by primary payer and diagnosis can indicate that certain sub-populations may have a high need that cannot be met locally.

[87] Percentages in rows may not add up to 100% because a small number of admissions (fewer than 1%) did not have an identified payer. The table does not include hospitals with fewer than 10 admissions in the reported period. These include 30 total admissions across CHRISTUS Spohn Corpus Christi – Shoreline, Corpus Christi Medical Center – Bay Area, Corpus Christi Medical Center – Doctors Regional, and Corpus Christi Medical Center – Northwest.

Map 7 shows where all Nueces County residents were admitted to psychiatric beds throughout Texas. The orange symbols represent the number of admissions from Nueces County. We have scaled these symbols to indicate the magnitude of admissions and have marked them with lettered labels that correspond to Table 28. Counties that had multiple hospitals with psychiatric beds that admitted Nueces County residents were aggregated into a single symbol to show the number of people who were admitted to hospitals in that particular county. Detailed hospital-level admissions are provided in Table 28, following the map. We obscured counts of fewer than six admissions to prevent patient re-identification.

As reported in Map 7 and the associated data table, below, hospitals that admitted the most Nueces County patients were in Nueces County: Bayview Behavioral Hospital, with 1,539 admissions, and CHRISTUS Spohn – Corpus Christi, with 1,491 admissions. Only 15% (522 admissions of 3,563 total admissions) of Nueces County residents were to non-local hospitals. In contrast, Table 27 reports 850 non-local admissions to Bayview Behavioral Hospital and 189 non-local admission to CHRISTUS Spohn – Corpus Christi. Many more non-local patients flow into Nueces County's psychiatric beds than local patients flow to beds outside of Nueces County.

Of the 522 admissions to non-local hospitals, about half (250) went to Bexar County, including 109 admissions to Laurel Ridge Treatment Center. Additionally, 103 admissions went to McAllen Medical Center in Hidalgo County, and 88 admissions went to Palms Behavioral Health in Cameron County. Additionally, 54 admissions went to state hospitals, including 39 that went to San Antonio State Hospital in Bexar County. Bexar, Hidalgo, and Cameron counties are each about a two-hour drive from Nueces County.

The bottom rows of Table 28 show the aggregated use of local and non-local beds broken out by age. Approximately the same proportion of each age group used non-local beds. This consistency supports the hypothesis that no single age group lacks beds.

Overall, few Nueces County residents received care outside of Nueces County. Of those who did, not all of the movement to distant hospitals was related to local access. For example, patients utilizing state hospitals often have forensic needs or more intensive need (e.g., comorbid intellectual and psychiatric disabilities) that required a more intensive setting than community hospitals.

Map 7: Residents of Nueces County: All Admissions to Psychiatric Beds (CY 2018)

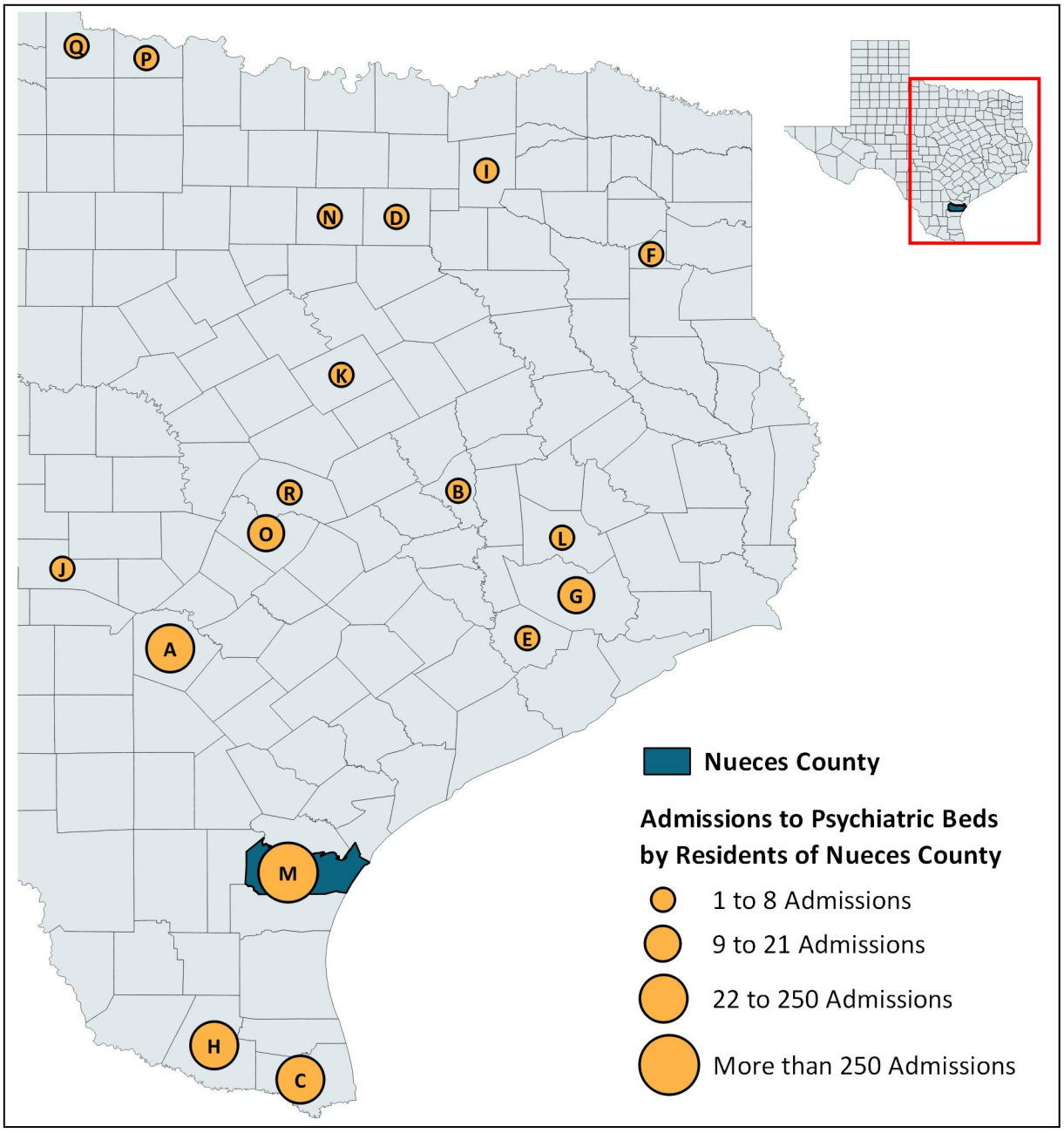


Table 28: Residents of Nueces County: Admissions to Psychiatric Beds by Age (CY 2018)

Map Label	County and Hospital	All Ages	Adults	Children and Youth
A	**Bexar**	**250**	**198**	**52**
	Clarity Child Guidance Center	<6	N/A	<6
	Laurel Ridge Treatment Center	109	70	39

Map Label	County and Hospital	All Ages	Adults	Children and Youth
	Methodist Specialty & Transplant Hospital	23	23	N/A
	Nix Behavioral Health Center	10–14	9	<6
	Nix Health Care System	24–28	23	<6
	Nix Specialty Health Center	9	9	N/A
	Northeast Baptist Hospital	<6	<6	N/A
	San Antonio Behavioral Healthcare Hospital	20–24	19	<6
	San Antonio State Hospital	39	39	N/A
	Southwest General Hospital	<6	<6	N/A
	University Hospital	<6	<6	N/A
B	**Brazos – Rock Prairie Behavioral Health**	**<6**	**<6**	**N/A**
C	**Cameron**	**91**	**67**	**24**
	Palms Behavioral Health	88	64	24
	Rio Grande State Center	<6	<6	N/A
	Valley Baptist Medical Center	<6	<6	N/A
D	**Dallas – Methodist Richardson Medical Center**	**<6**	**<6**	**N/A**
E	**Fort Bend – Westpark Springs**	**<6**	**<6**	**N/A**
F	**Gregg – Oceans Behavioral Hospital of Longview**	**<6**	**<6**	**N/A**
G	**Harris**	**21**	**21**	**N/A**
	Behavioral Hospital – Bellaire	<6	<6	N/A
	Harris County Psychiatric Center	<6	<6	N/A
	Houston Behavioral Healthcare Hospital	<6	<6	N/A
	Houston Methodist Hospital	<6	<6	N/A
	IntraCare North Hospital	<6	<6	N/A
	Lone Star Behavioral Health Cypress	<6	<6	N/A
	Menninger Clinic	<6	<6	N/A
	Oceans Behavioral Hospital of Katy	<6	<6	N/A
	Sun Behavioral Houston	<6	<6	N/A
H	**Hidalgo**	**110**	**79**	**31**
	Doctors Hospital-Renaissance	7	7	N/A
	McAllen Medical Center	103	72	31
I	**Hunt – Glen Oaks Hospital**	**<6**	**<6**	**N/A**

Map Label	County and Hospital	All Ages	Adults	Children and Youth
J	**Kerr – Kerrville State Hospital**	**<6**	**<6**	**N/A**
K	**McLennan – DePaul Center**	**<6**	**<6**	**N/A**
L	**Montgomery**	**<6**	**<6**	**N/A**
	Aspire Hospital	<6	<6	N/A
	Woodland Springs	<6	<6	N/A
M	**Nueces**	**3,041**	**2,383**	**658**
	Bayview Behavioral Hospital	1,539	885	654
	CHRISTUS Spohn – Corpus Christi	1,491	1,491	N/A
	CHRISTUS Spohn Hospital Corpus Christi – Shoreline	<6	<6	N/A
	Corpus Christi Medical Center – Bay Area	<6	<6	<6
	Corpus Christi Medical Center– Doctors Regional	<6	<6	N/A
	Corpus Christi Medical Center – Northwest	<6	N/A	<6
N	**Tarrant – Sundance Hospital**	<6	<6	<6
O	**Travis**	**20–24**	**19**	<6
	Austin Lakes Hospital	<6	<6	N/A
	Austin Oaks Hospital	<6	<6	N/A
	Austin State Hospital	<6	<6	<6
	Seton Shoal Creek Hospital	6	6	N/A
	Texas NeuroRehab Center	<6	<6	N/A
P	**Wichita – North Texas State Hospital**	**<6**	**<6**	**N/A**
Q	**Wilbarger – North Texas State Hospital-Vernon**	**6**	**6**	**N/A**
R	**Williamson**	**8–12**	**7**	<6
	Georgetown Behavioral Health Institute	<6	<6	<6
	Rock Springs	<6	<6	N/A
Total Admissions		**3,563**	**2,794**	**769**
Admissions to Local Nueces Hospitals		3,041	2,383	658
Admissions to Non-Local Hospitals		522	411	111
Admissions to State Hospitals		53–57	52	<6

Table 29 summarizes the previous table by payer. Nueces County residents who received care in non-local hospitals were more likely to be funded through other government (10%) or commercial insurance (37%), compared to patients who received care locally (2% other

government, 22% commercial insurance). Residents who received care locally were more likely to be funded through Medicaid (34% vs. 18%) and were slightly more likely to be self-funded (24% vs. 19%). These differences reflect the broader range of options for patients with commercial insurance, but they are not large enough to indicate a lack of access for self-funded patients.

Table 29: Residents of Nueces County, Admissions to Psychiatric Beds Statewide by Payer – All Ages (CY 2018)

Hospital	Total Admissions	Medicaid	Medicare	Other Gov't.	Self-Pay	Commercial Insurance
Admissions to Local Hospitals[88]	**3,041**	**34%**	**17%**	**2%**	**24%**	**22%**
Bayview Behavioral Hospital	1,539	44%	14%	2%	19%	19%
CHRISTUS Spohn Hospital Corpus Christi	1,491	23%	20%	3%	29%	24%
Admissions to Non-Local Hospitals	**522**	**18%**	**16%**	**10%**	**19%**	**37%**
Admissions to State Hospitals	54	0%	0%	0%	100%	0%
Admissions to Other Non-Local Hospitals	468	20%	18%	12%	9%	41%
Total Admissions to All Hospitals	**3,563**	**32%**	**17%**	**4%**	**23%**	**24%**

Finally, the following table (Table 30) contrasts daily capacity and utilization of psychiatric beds in Nueces County. The table presents an overview of per-day average psychiatric bed utilization for each hospital from November 2015 through November 2018. It shows that on most days, psychiatric beds were available at both CHRISTUS Spohn – Corpus Christi and at Bayview Behavioral Hospital.

[88] Some hospitals only had a handful of admissions. These admissions are included in totals but are not provided as individual hospital breakouts. These include 11 admissions to CHRISTUS Spohn – Shoreline, Corpus Christi Medical Center – Bay Area, Corpus Christi Medical Center – Doctors Regional, and Corpus Christi Medical Center – Northwest hospitals.

Table 30: Average Daily Psychiatric Utilization and Capacity – Nueces County (CY 2018)[89]

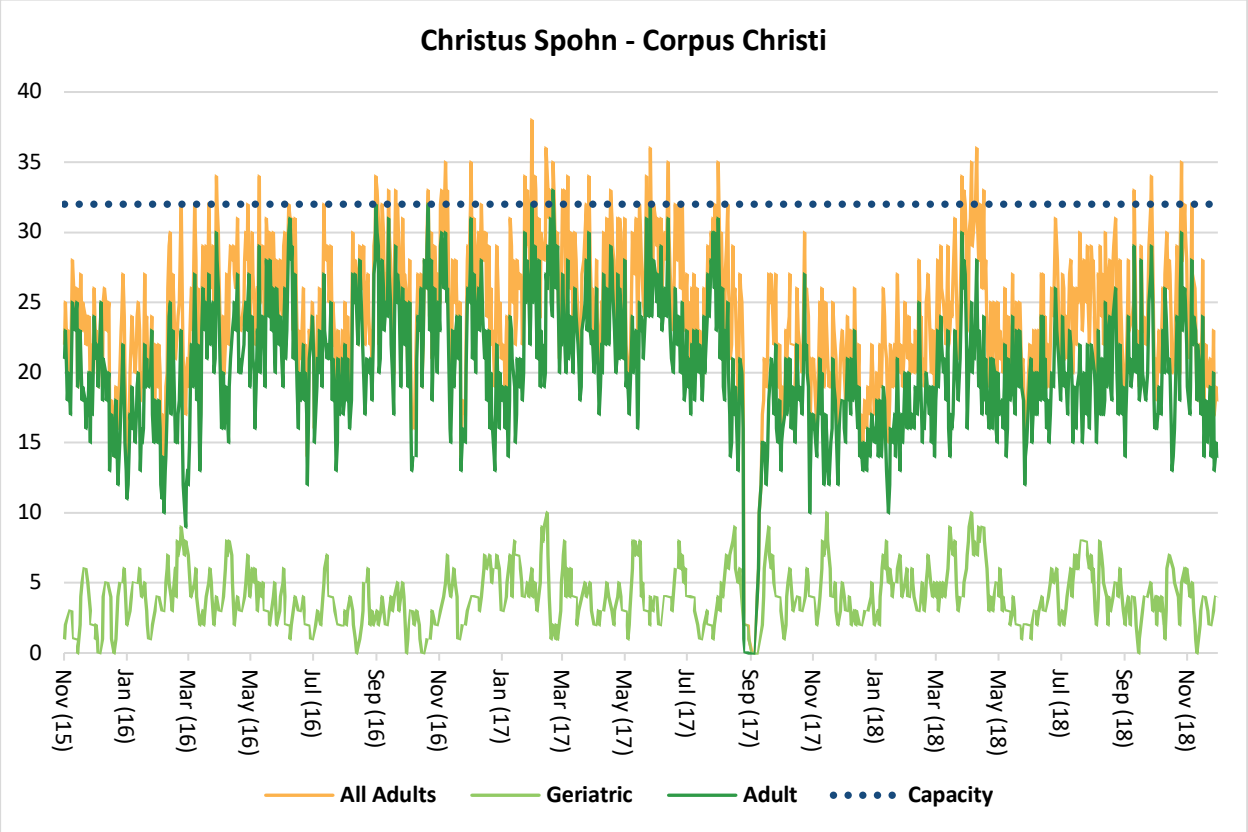
Type of Utilization	CHRISTUS Spohn Hospital Corpus Christi	Bayview Behavioral Hospital
Adult Utilization		
Average Daily Utilization	24	23
Utilization as a Percentage of Capacity	75%	71%
Percentage of Days with Available Beds	94%	81%
Child and Youth Utilization		
Average Daily Utilization	N/A	17
Utilization as a Percentage of Capacity	N/A	70%
Percentage of Days with Available Beds	N/A	87%

The time series charts in figures 2 and 3 show day-by-day analysis for each hospital between January 2016 and November 2018. Figure 2 reveals that CHRISTUS Spohn – Corpus Christi occasionally operated beyond its capacity, though, as Table 30 shows, the vast majority (94%) of days had bed availability.

[89] Hospitals with small counts of psychiatric bed utilization (hospitals that on average, do not have at least one person in a bed on any given day) and hospitals without a reported psychiatric bed capacity are not included. These hospitals are CHRISTUS Spohn Corpus Christi – Shoreline, Corpus Christi Medical Center – Northwest, Corpus Christi Medical Center – Heart Hospital, Corpus Christi Medical Center – Bay Area, and Corpus Christi Medical Center – Doctors Regional Hospital.

Christus Spohn – Corpus Christi

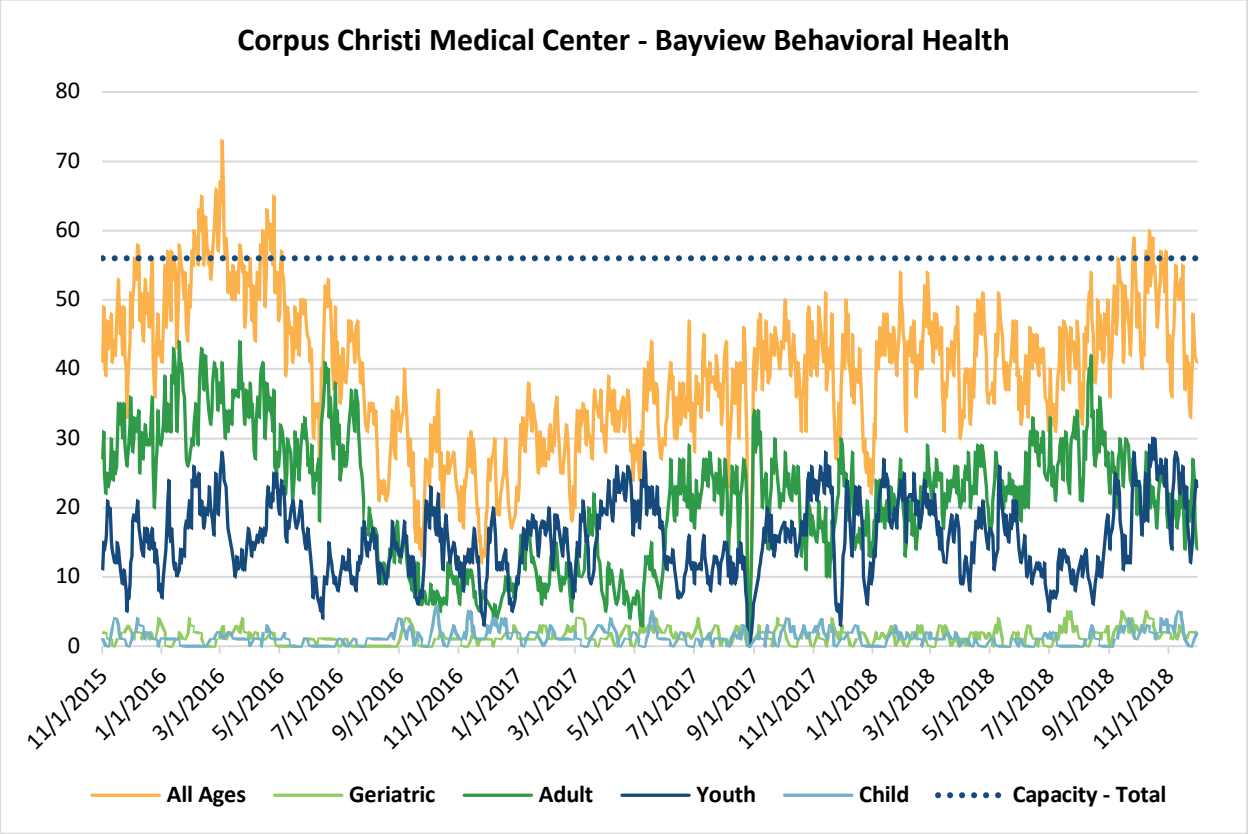
Figure 2: CHRISTUS Spohn – Corpus Christi Daily Utilization Versus Capacity (January 2016–November 2018)



At Bayview Behavioral Hospital, 23 adults and 17 children and youth, on average, occupied beds each day (40 total across age groups) compared to 56 available beds, including 24 pediatric beds. Thus, although many of the beds were being occupied (70% overall as shown in Table 30), the hospital was not usually operating over capacity. Figure 3 presents the points throughout the time period when utilization exceeded capacity. Despite multiple periods when the hospital exceeded capacity, beds were available most days (81% to 87%, depending on age group; see Table 30). Based on data beginning in November 2015, the time series graph (Figure 3) shows a trend in increased bed utilization over time, with the greatest utilization and concentrations of days operating at capacity during the end of 2018. A continuation of this trend will result in a lack of available beds at Bayview Behavioral Hospital.

Bayview Behavioral Hospital

Figure 3: Bayview Behavioral Hospital Daily Utilization Versus Capacity (January 2016–November 2018)



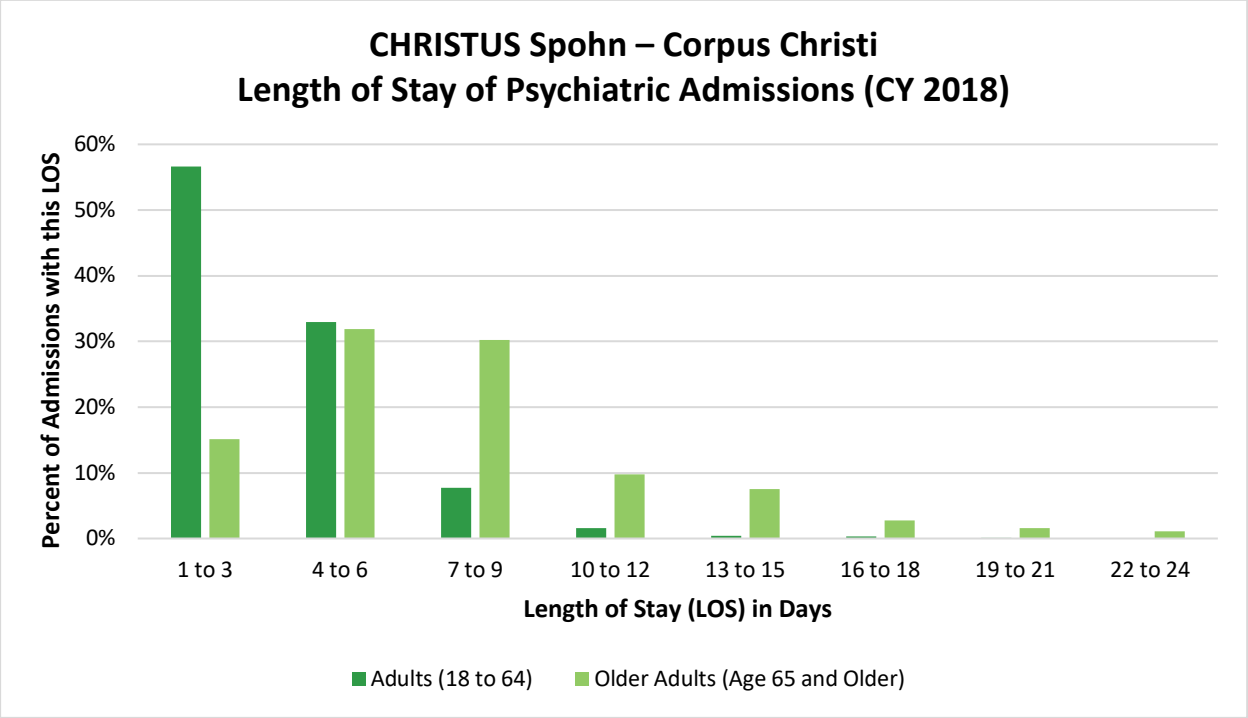
We conclude that Nueces County has sufficient local inpatient psychiatric beds to meet the needs of local residents. Our conclusion is based on the following key findings:

- When we examine subpopulations of patients by age and payer type, we do not observe disproportionality in bed use consistent with limited local access.
- The number of patients from other counties who use Nueces County psychiatric beds exceeds the number of Nueces County patients who use beds in other counties.
- On most days, inpatient beds are available at each hospital.

Although there appears to be sufficient local psychiatric beds to meet current needs, it is also useful to examine bed utilization for signs of gaps in care for community-based outpatient services. Poor access to outpatient services, or insufficient capacity in certain types of services, will result in unnecessary inpatient bed use. Several features of inpatient bed use help identify problems with the availability of outpatient services. This includes analysis of length of stay, co-occurring psychiatric and substance use disorders, and comorbid behavioral and medical conditions.

Figure 4 shows the lengths of stay at CHRISTUS Spohn – Corpus Christi by age group. Most adults between the ages of 18 and 64 has a length of stay of just one to three days. Older adults above age 64 stayed for somewhat longer, but still fewer than 10% stayed for longer than two weeks. CHRISTUS Spohn – Corpus Christi does not report utilization for children or youth. The length of stay analysis at CHRISTUS Spohn – Corpus Christi shows rapid stabilization and discharge for adults, but less so for older adults.

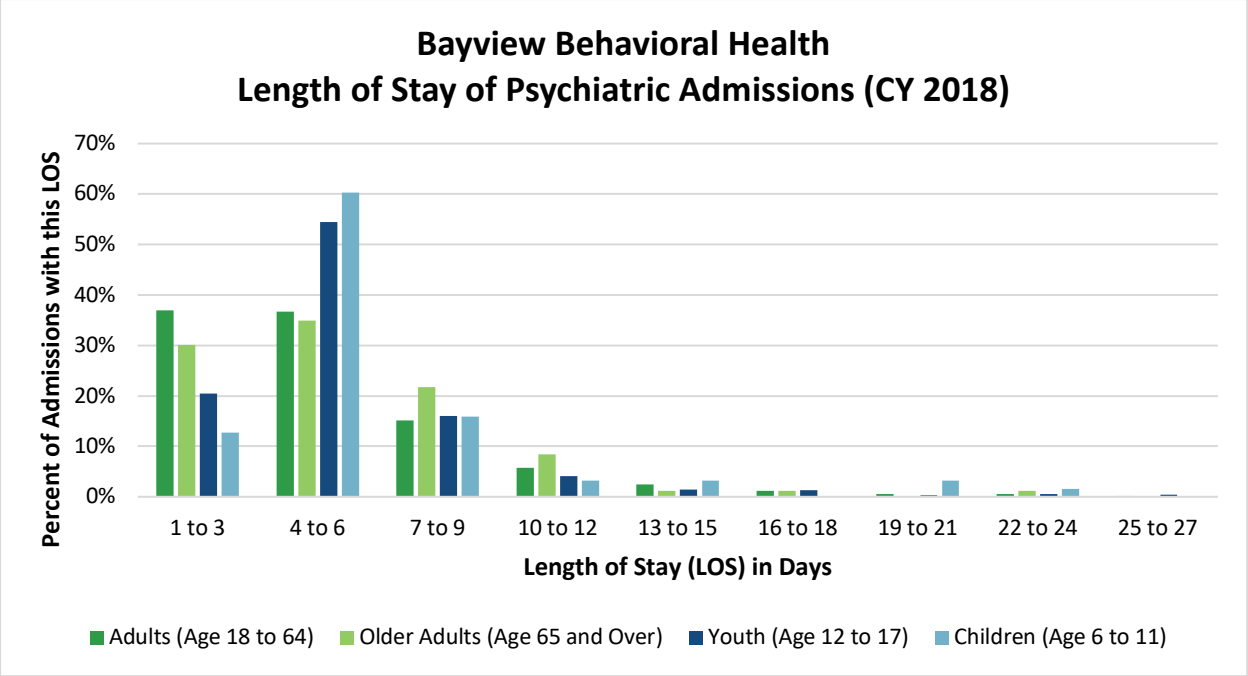
Figure 4: Christus Spohn – Corpus Christi Length of Stay Details[90]



The average length of stay graph for Bayview Behavioral Hospital shows a more muted difference between adults and older adults, but it still shows longer lengths of stay for the older population. A disproportionate number of children and youth had lengths of stay between four and six days, with some utilization of more than two weeks.

[90] Of the 1,680 total admissions, only five people had lengths of stay of more than 24 days. These are not displayed on the graph.

Figure 5: Bayview Behavioral Hospital Length of Stay Details[91]



The extended length of inpatient stays for older adults may reflect a lack of stepdown to skilled nursing facilities, forcing older patients to remain hospitalized beyond what is medically necessary. Or it may reflect conditions in older populations that are more difficult to stabilize. Chart reviews and analysis of the availability of skilled nursing facilities could help clarify if inpatient bed use in Nueces County hospitals may be reduced for older patients with mental illness.

Extended lengths of stay for some children and youth at Bayview Behavior Hospital also warrant further investigation. These cases are relatively rare, but in other Texas hospitals, extended hospitalization has occasionally occurred for children and youth in the foster care system who are unable to be placed with families. Because of the disruption caused by extended inpatient episodes, these cases should be reviewed to rule out systematic problems in the child welfare system.

Tables 31 through 35 report psychiatric bed utilization by Nueces County residents, by diagnoses, including substance use disorders and other comorbid conditions. Table 31 shows the number of people from Nueces County who were admitted to a psychiatric bed in calendar year (CY) 2018, and the percentage of these patients with any substance use disorder diagnosis. The remaining balance of patients predominantly had psychiatric diagnoses. Among those

[91] Of all admissions, only 23 people (3%) had lengths of stay longer than 24 days. These are not included on the graph.

admitted locally, approximately 44% had a substance use disorder (SUD) – almost identical to the 45% of admissions to non-local hospitals. However, a higher proportion of admissions to CHRISTUS Spohn – Corpus Christi had SUD (51%) compared to Bayview Behavioral Hospital. This variance may result from CHRISTUS Spohn – Corpus Christi not admitting children and youth, who typically have lower rates of SUD than adults.

Table 31: Residents of Nueces County, Admissions to Psychiatric Beds for Psychiatric Versus Substance Use Disorder Admissions – All Ages (CY 2018)

Age Group	Total Admissions	Percentage of Admissions with Any SUD Diagnosis
Admissions to Nueces Hospitals[92]	**3,041**	**44%**
Bayview Behavioral Hospital	1,539	37%
CHRISTUS Spohn – Corpus Christi	1,491	51%
Admissions to Other Non-Local Hospitals	**522**	**45%**

Table 32 shows the number of people admitted to psychiatric beds with co-occurring psychiatric and substance use conditions, broken out by the primary diagnosis (psychiatric versus substance-related conditions as the primary diagnosis). The table shows that several people with primary psychiatric diagnoses had co-occurring substance use disorders. This was true for 1,241 of 2,899 admissions to local beds (43% of local admissions) and for 151 of 482 (31%) of non-local admissions. Among 99 admissions to psychiatric beds with a primary substance use disorder (including 68 to local beds and 31 to non-local beds), most (82) had a co-occurring psychiatric disorder.

Table 32: Residents of Nueces County, Admissions of Patients with Co-Occurring Psychiatric and Substance Use Disorders – All Ages (CY 2018)[93]

Hospital of Admission	Primary Psychiatric Diagnosis		Primary Substance Use Diagnosis	
	Admissions	Admissions with Secondary SUD Diagnoses	Admissions	Admissions with Secondary Psychiatric Diagnoses
All Admissions to Local Nueces County Beds	**2,899**	**1,241**	**67 – 71**	**58 – 62**

[92] There were 11 admissions to other hospitals in Nueces County. These are included in totals but not in separate breakouts because of low counts.

[93] In addition to the 3,382 admissions with a primary psychiatric diagnosis and the 1,392 admissions with a primary SUD diagnosis, 82 admissions had a primary "other" diagnosis. These "other" diagnoses, although not psychiatric diagnoses, were those that are often the result of, or contribute to, psychiatric symptoms. These include diagnoses such as Alzheimer's disease, open physical wounds, and carbon monoxide poisoning.

Hospital of Admission	Primary Psychiatric Diagnosis		Primary Substance Use Diagnosis	
	Admissions	Admissions with Secondary SUD Diagnoses	Admissions	Admissions with Secondary Psychiatric Diagnoses
Admissions to Bayview Behavioral Hospital	1,437	491	66	57
Admissions to CHRISTUS Spohn – Corpus Christ	1,455	749	<6	<6
Admissions to Non-Local Beds	**483**	**151**	**31**	**23**
All Admissions (to Local and Non-Local Beds)	**3,382**	**1,392**	**98 – 102**	**81 – 85**

The high number of psychiatric bed admissions related to substance use disorders is consistent with Table 6 and Table 13. National Survey On Drug Use and Health sub-state results show that most people in need of treatment for substance use in Texas do not receive care. If Nueces County followed a similar trend, then almost none of the 15,000 Nueces adults and 1,000 youth with a substance use disorder would receive treatment. The lack of access to community-based SUD treatment would result in crisis use of psychiatric beds.

As reported in Table 33, the most common psychiatric diagnosis among Nueces County residents seeking inpatient care was major depressive disorder followed by bipolar disorder, then schizoaffective disorders. However, among those who received care in non-local hospitals, the top diagnosis was bipolar disorder, followed by major depressive disorder (MDD in Table 33).

Table 34 shows the most common comorbid physical conditions among Nueces residents receiving inpatient care. Among residents admitted locally and non-locally for psychiatric conditions, some of the most common physical conditions are nicotine dependence, primary hypertension, and hyperlipidemia.

Table 33: Residents of Nueces County, Top 10 Primary Diagnoses Associated with Admissions to Local and Non-Local Psychiatric Beds – All Ages (CY 2018)

Rank	All Admissions to Inpatient Psychiatric Beds		Admissions to Local Inpatient Beds		Admissions to Non-Local Inpatient Beds	
	Top Primary Diagnoses	Admissions	Top Primary Diagnoses	Admissions	Top Primary Diagnoses	Admissions
Total		**3,551**		**3,030**		**521**
1	MDD Recurrent	1,436	MDD, Recurrent	1,335	Bipolar Disorder	124

Rank	All Admissions to Inpatient Psychiatric Beds		Admissions to Local Inpatient Beds		Admissions to Non-Local Inpatient Beds	
	Top Primary Diagnoses	Admissions	Top Primary Diagnoses	Admissions	Top Primary Diagnoses	Admissions
2	Bipolar Disorder	604	Bipolar Disorder	480	MDD, Recurrent	101
3	Schizoaffective Disorders	419	Schizoaffective Disorders	333	Schizoaffective Disorders	86
4	MDD, Single Episode	340	MDD, Single Episode	278	MDD, Single Episode	62
5	Schizophrenia	161	Schizophrenia	129	Schizophrenia	32
6	Alcohol-Related Disorders	111	Alcohol-Related Disorders	88	Persistent Mood Disorders	24
7	Adjustment Disorders	72	Adjustment Disorders	58	Alcohol-Related Disorders	23
8	Persistent Mood Disorders	67	Unspecified Mood Disorder	52	Adjustment Disorders	14
9	Unspecified Mood Disorder	55	Persistent Mood Disorders	43	Unspecified Mood Disorder	10
10	Unspecified Psychosis	48	Unspecified Psychosis	38	Impulse Disorders	10

Table 34: Residents of Nueces County, Top 10 Secondary Physical Health Diagnoses Associated with Admissions to Local and Non-Local Psychiatric Beds – All Ages (CY 2018)

Rank	All Admissions to Inpatient Psychiatric Beds		Admissions to Local Inpatient Beds		Admissions to Non-Local Inpatient Beds	
	Top Physical Health Diagnoses	Admissions	Top Physical Health Diagnoses	Admissions	Top Physical Health Diagnoses	Admissions
Total		**21,909**		**19,191**		**2,718**
1	Nicotine Dependence	1,228	Nicotine Dependence	1,106	Nicotine Dependence	122
2	Primary Hypertension	777	Primary Hypertension	678	Personal Risk Factors, Not Classified	109
3	Cannabis-Related Disorders	665	Cannabis-Related Disorders	595	Primary Hypertension	99
4	Personal Risk Factors, Not Classified	644	Allergy to Substance	578	Sleep Disorders	90

Rank	All Admissions to Inpatient Psychiatric Beds		Admissions to Local Inpatient Beds		Admissions to Non-Local Inpatient Beds	
	Top Physical Health Diagnoses	Admissions	Top Physical Health Diagnoses	Admissions	Top Physical Health Diagnoses	Admissions
5	Allergy to Substance	592	Personal Risk Factors, Not Classified	535	Cannabis-Related Disorders	70
6	Alcohol Related Disorders	560	Alcohol Related Disorders	507	ADHD	64
7	Other Fluid, Electrolyte, Acid-Base Balance Disorder	496	Other Fluid, Electrolyte, Acid-Base Balance Disorder	482	Type 2 Diabetes	55
8	Hyperlipidemia	415	Hyperlipidemia	369	Alcohol-Related Disorders	53
9	Cocaine-Related Disorders	404	Cocaine-Related Disorders	360	Hyperlipidemia	46
10	Type 2 Diabetes	404	Asthma	357	Cocaine-Related Disorders	44

Table 35 shows the top physical health diagnoses among people with secondary psychiatric conditions, substance use disorders, and or co-occurring psychiatric and substance use disorders (COPSD). The most common primary condition among these patients was sepsis. Type 2 diabetes and acute kidney failure were also among the most prevalent medical conditions for this group. People who had secondary psychiatric diagnoses (but not substance-related diagnoses) most commonly had osteoarthritis, femur fracture, or were overweight. Type 1 diabetes was one of the most common conditions among people with COPSD (but not psychiatric or SUD disorders alone). Finally, among people with SUD diagnoses (but not psychiatric disorders), liver disease and cerebral infarction (stroke) were in the top 10 physical diagnoses.

Table 35: Medical Inpatient Hospitalizations of Nueces Residents with Co-Occurring Psychiatric and Substance Use Disorders – All Ages (CY 2018)

Rank	Top Primary Physical Diagnoses with Secondary Psychiatric Diagnoses		Top Primary Physical Health Diagnoses with Secondary SUD Diagnoses		Top Primary Physical Health Diagnoses with Secondary COPSD Diagnoses	
	Physical Health Diagnosis	Secondary Psychiatric Admissions	Physical Health Diagnosis	Secondary SUD Admissions	Physical Health Diagnosis	Secondary COPSD Admissions
Total		**4,874**		**1,387**		**504**
1	Sepsis	292	Sepsis	118	Sepsis	43

Rank	Top Primary Physical Diagnoses with Secondary Psychiatric Diagnoses		Top Primary Physical Health Diagnoses with Secondary SUD Diagnoses		Top Primary Physical Health Diagnoses with Secondary COPSD Diagnoses	
	Physical Health Diagnosis	Secondary Psychiatric Admissions	Physical Health Diagnosis	Secondary SUD Admissions	Physical Health Diagnosis	Secondary COPSD Admissions
2	Osteoarthritis of Knee	174	Alcoholic Liver Disease	59	Cellulitis and Acute Lymphangitis	23
3	Chronic Obstructive Pulmonary Disease	124	Heart Attack	50	Acute Pancreatitis	15
4	Fracture of Femur	113	Cellulitis and Acute Lymphangitis	49	Type 1 Diabetes	15
5	Overweight and Obesity	103	Acute Pancreatitis	40	Epilepsy and Recurrent Seizures	15
6	Acute Kidney Failure	101	Cerebral Infarction	39	Acute Kidney Failure	14
7	Type 2 Diabetes	101	Acute Kidney Failure	36	Cutaneous Abscess	14
8	Pneumonia	95	Type 2 Diabetes	35	Alcoholic Liver Disease	13
9	Spondylopathies	90	Chronic Obstructive Pulmonary Disease	25	Type 2 Diabetes	11
10	Heart Attack	80	Skull/Facial Fracture	23	Other Diseases of Digestive System	11

Summary Takeaways

- The majority of Nueces County residents are Hispanic or Latino, and a higher proportion of Hispanic or Latino people live in poverty than non-Hispanic Whites (Table 2 and Table 8). By the year 2050, the population among all age groups is expected to increase, with the population of adults over the age of 65 growing at the fastest rate (see Table 3 and Table 9). Based on these projections, **the underlying need for behavioral health services for children and youth in Nueces County should show modest growth through 2050, while the need for behavioral health services for older adults may increase disproportionately to other age groups.**

- In 2017, approximately 5,000 Nueces County children and youth had serious emotional disturbances (SED) (Table 5), and about 10,000 to 15,000 adults had serious mental illnesses (SMI) (Table 11). Across all ages, about half of those with SED or SMI lived in poverty. When contrasting counts of people served by setting at Behavioral Health Center of Nueces County to the estimated number of people living in poverty with SED or SMI (Tables 13 through 18), we found that **there was a large gap in care for children and youth with serious emotional disturbances (SED) who were living in poverty, and just 34% of adults in need received care through the LMHA.**
- Two hospitals in surrounding counties have not provided psychiatric inpatient care for more than a year (and one closed because of Hurricane Harvey). However, based on the usual availability of inpatient psychiatric beds and the use of 25% of current beds by residents of counties outside the region, Nueces area hospitals do not appear to have a shortage of inpatient capacity (Table 30).
- In 2018, people were over five times more likely to visit the ED for psychiatric diagnoses than for SUD diagnoses (Table 19). This ratio matches the prevalence data, which show that the prevalence of all mental health conditions is about five times that of SUD.
- Although there appears to be enough local capacity overall, admissions by people with lower-rate funding sources may be straining local resources.
  - **People visiting the ED who were then placed in a psychiatric bed were more often placed in local beds when their care was self-funded, and placed in non-local beds when their care was funded through commercial insurance**. Among people who were hospitalized in a psychiatric bed after visiting a Nueces County ED, more than half were hospitalized locally, indicating a typically sufficient local capacity to meet the local need. However, people who were funded through Medicaid, other government funds, or were self-funded were more often hospitalized locally, whereas people who were funded through Medicare or commercial insurance are more often hospitalized non-locally (Table 24).
  - **A higher proportion of Nueces County residents were admitted locally when self-funded**. Among Nueces County residents who received inpatient care, those who received care locally were more likely to be funded through Medicaid or self-funded than were those who received care outside of the county. In contrast, patients who received care outside of the county were more likely to be funded through commercial insurance (Table 29).
  - **Self-pay and Medicare patients were less likely to receive inpatient care after visiting an ED**. A comparison of all psychiatric ED visits (Table 19) to psychiatric ED visits that resulted in inpatient hospitalization (Table 24) showed that people who were self-funded or funded through Medicare received inpatient care less frequently after visiting an ED, whereas people with commercial insurance received care more frequently when compared to payer proportions among total psychiatric ED visits.

Appendix One: Prevalence Estimation Methodology

Introduction

To provide meaningful estimates based on the most rigorous and contemporary epidemiological sources available regarding overall numbers (prevalence) for serious emotional disturbance (SED) and serious mental illness (SMI), we have utilized the work of Dr. Charles Holzer.[94] In 2014, Dr. Holzer worked on behalf of MMHPI to estimate the prevalence of SMI in Texas counties using 2012 and earlier data.[95] We believe that Dr. Holzer's original SED and SMI estimates and our adaptation of his data, findings, and methodologies to more recent Texas populations provide the most practically relevant estimates available. The method, described in more detail below, uses statistical formulas that apply national prevalence findings to Texas population and demographic data.

Estimating the prevalence of specific mental illnesses such as bipolar disorder, depression, or schizophrenia in different age groups (e.g., children, youth, adults) is a more complicated endeavor – one requiring us to incorporate the best available national studies of the prevalence of those specific disorders. In cases where these more specific epidemiological sources are used, these are always cited, and in all cases represent, what we judge to be the best available, sufficiently contemporary source.

Holzer and "Horizontal Synthetic Estimation"

Beginning with his work at the University of Florida in the 1970s, Holzer drew connections between established data (drawn largely from census data), demographics, and the careful study of how these factors correlated with various needs among populations.[96] Holzer derived principles about these connections as presented in the Mental Health Demographic Profile System (MHDPS). This system matched demographic data from the Florida Health Survey with community demographics and known needs for mental health services, creating a model for estimating need in places and situations in which survey data were not available.

The method, which those in the MHDPS team termed "Horizontal Synthetic Estimation," evolved as Holzer refined his work. A crucial step came in the 1980s following the National Institute of Mental Health's Epidemiologic Catchment Area (ECA) program, the largest

[94] Charles E. Holzer III, PhD, is an esteemed psychiatric epidemiologist who has worked and published in behavioral science for forty years.

[95] In 2014, MMHPI hired Dr. Holzer to perform a revised county-level prevalence estimate throughout Texas. Dr. Holzer licensed the study and methodology to MMHPI on an ongoing basis. If referencing prevalence estimates from this report, please include this citation: Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2015*. Dallas, TX: Meadows Mental Health Policy Institute.

[96] Unless otherwise cited, the information presented is from Dr. Holzer's web page at http://172.10.175.217/estimation/estimation.htm

psychiatric epidemiological study in the United States at the time. Holzer used ECA findings to develop a series of prevalence estimates for the Texas Department of Mental Health and Retardation, a project which led to several similar projects, including estimates in Colorado, Ohio, and Washington State. Following the 1990 Census and the 1993 National Comorbidity Survey (NCS), Holzer developed estimates in other states, including Colorado, Wyoming, and Nebraska, among others, and included county-level prevalence estimates.

Holzer's method represented a departure from less-precise methods. First, he argued, the extant approaches that relied on service utilization mistakenly assumed that local mental health systems served all people with mental health needs. He also criticized some forms of indirect estimation, such as those that used social indicators (crime levels, poverty, divorce, etc.), with no reference to actual data on mental illnesses.

Holzer argued that if prevalence estimates and their correlates with demographic characteristics from national epidemiological studies were applied to state and county populations, he could provide more precise estimates of mental health need. He used statistical methods that analyzed survey data from the 2001–2003 Collaborative Psychiatric Epidemiology Surveys (CPES)[97] to estimate the relationships between seven socio-demographic characteristics (i.e., age, sex, race/ethnicity, marital, education, poverty, housing status) and SED and SMI prevalence rates.[98] He then applied these rates to the most up-to-date, available county- or state-level American Community Survey (ACS)[99] population and demographic data, which include estimates of the number of people who can be categorized by the same seven socio-demographic characteristics.

MMHPI Adaptation of Holzer's Methodology and Data

In 2014, MMHPI hired Dr. Holzer to perform a revised county-level estimate throughout Texas using 2012 Three-Year ACS data (the most recently available data at the time). Dr. Holzer then licensed the methodology to MMHPI for use in estimating prevalence in Texas. From this work, and by using Dr. Holzer's findings, especially his 2012 estimates of the MMHPI-commissioned study of Texas, we have developed a new series of 2017 estimates utilizing the 2017 ACS Five-Year dataset and the 2017 Population Estimates. These data were the most current at the time of our analysis.

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[97] The CPES is a collaboration that includes the NCS-R, NLAAS, and NSAL combined. See http://172.10.175.217/estimation/documentation/CPES/cpes.htm

[98] Detailed information on Dr. Holzer's method is available at http://172.10.175.217/estimation/estimation.htm

[99] The ACS is an extension of the U.S. Census Bureau. It is an ongoing statistical survey that gathers significant data that, among other things, track shifting demographic data. The use of ACS data helps to align the Holzer estimates with the most up-to-date information on key demographic information.

Estimating the Prevalence of Specific Disorders

In estimating the prevalence of specific disorders, we draw on the most recent national prevalence studies conducted by psychiatric epidemiologist Ron Kessler and colleagues, as well as on reviews of prevalence studies that target specific disorders. The two primary national studies are the National Comorbidity Survey Replication (NCSR)[100] and the National Comorbidity Survey Replication-Adolescent Supplement (NCSR-A).[101] These studies provide national estimates of specific disorders. We then apply these estimates to the Texas populations of the same age groups (all adults ages 18+ and adolescents ages 12–17, respectively).

The national studies did not include all disorders of interest. For example, because of its very low prevalence rate, schizophrenia was not included in the NCSR. In cases of missing diagnoses in the NCSR or SCSR-A, we rely on what we determine to be the best available reviews of epidemiological studies specific to each diagnosis.[102]

[100] Kessler, R.C., et al. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627.

[101] Kessler, R.C., et al. (2012). Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 381–389.

[102] See for example McGrath, J., et al. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews, 30*, 67–76.

Appendix Two: Nueces Hospital Data and Methodology

We drew our data for emergency department and inpatient psychiatric bed use from the Texas Health Care Information Collection (THCIC). THCIC comprises inpatient, emergency department, and outpatient discharge records for hospitals operating throughout Texas. Each discharge record included details on the client's age, length of stay, county of residence, charges (which reflect the nominal amount billed for each service), primary payer type, and source of admission, among other variables. To analyze the many sources of funding included in records, payer types were grouped into one of five categories for the purposes of this analysis: Medicaid, Medicare, Other Governmental Payer, Self-Pay, and Commercial Insurance.

These THCIC discharge records were used to analyze psychiatric inpatient and emergency department utilization in Nueces County and across Texas, as depicted in the maps and data tables in this report. While we currently have data from 2015 through the fourth quarter of calendar year (CY) 2018, the data in the maps and tables are limited to a single full year of data – January 2018 through December 2018, with the exception of the daily utilization graphs, which report utilization as far back as January 2016. Discharge records were either reported by age group or aggregated across all age groups, as described in the table titles.

Hospital capacity data were obtained from the American Hospital Association's (AHA) 33rd Annual Survey of Hospitals (for year 2017). We reported the number of beds that are staffed for use by each hospital. However, if the hospital reported an alternate number of available beds in the most recent in-person interviews, we used that reported capacity in lieu of the AHA reported capacity.

Presentation of the BeHealthle report has been postponed until the January 21, 2020 Board of Managers meeting.

Information to be presented at meeting.

CHRISTUS SPOHN Health System

November 27, 2019

Mr. Jonny Hipp, ScD, FACHE
Administrator/Chief Executive Officer
Nueces County Hospital District
555 North Carancahua St., Suite #950
Corpus Christi, TX 78401-0835

Dear Jonny,

Effective January 1, 2020, CHRISTUS Spohn would like to provide our Nueces County Hospital District (NCHD) patients with 90-day supplies of certain prescriptions for common chronic diseases such as high blood pressure and diabetes. While we understand that this is outside the current NCHD handbook guidelines, we believe that by supplying the 90-day quantity, barriers such as lack of transportation, and timely-appointment availability for refills will be minimized and help provide better outcomes for our patients and reduce unnecessary emergency room visits.

We will be happy to work through the details with you and your team but first wanted to see if we could get this approved so we could move forward and enhance the services for our patients.

Sincerely,

Osbert Blow, MD, PhD, FACS
President & Chief Medical Officer
CHRISTUS Spohn Health System

Cc: Belinda Chism, Associate Administrator
Nueces County Hospital District

Humberto Ramos, Director of Clinical Operations
Dr. Hector P. Garcia Memorial Family Health Center

COLLIER, JOHNSON & WOODS, P.C.
CERTIFIED PUBLIC ACCOUNTANTS

555 N. Carancahua Suite 1000
Corpus Christi, Texas 78401-0839
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www.cjw-cpa.com

October 7, 2019

To the Board of Managers of the
Nueces County Hospital District
Corpus Christi, Texas

We are engaged to audit the financial statements of the governmental activities, each major fund, and the aggregate remaining fund information of Nueces County Hospital District for the year ended September 30, 2019. Professional standards require that we provide you with following information related to our audit. We would also appreciate the opportunity to meet with you to discuss the information further since a two-way dialogue can provide valuable information for the audit process.

Our Responsibility under U.S. Generally Accepted Auditing Standards

As stated in our engagement letter dated October 7, 2019, our responsibility, as described by professional standards, is to express opinions about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit of the financial statements does not relieve you or management of your responsibilities.

Generally accepted accounting principles provide for certain required supplementary information (RSI) to supplement the basic financial statements. Our responsibility with respect to the Management's Discussion and Analysis, which supplements the basic financial statements, is to apply certain limited procedures in accordance with generally accepted auditing standards. However, the RSI will not be audited and, because the limited procedures do not provide us with sufficient evidence to express and opinion or provide any assurance, we will not express an opinion or provide any assurance on RSI.

We have been engaged to report on the Budget Comparisons, which accompany the financial statements but are not RSI. Our responsibility for the supplementary information accompanying the financial statements, as described by professional standards, is to evaluate the presentation of the supplementary information in relation to the financial statements as a whole and to report on whether the supplementary information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Planned Scope and Timing of the Audit

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested.

Our audit will include obtaining an understanding of the entity and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Material misstatements may result from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws of governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity. We will generally communicate our significant findings at the conclusion of the audit. However, some matters could be communicated sooner, particularly if significant difficulties are encountered during the audit where assistance is needed to overcome the difficulties or if the difficulties may lead to a modified opinion. We will also communicate any internal control related matters that are required to be communicated under professional standards.

We expect to begin our audit in November 2019 and issue our report no later than January 2020. Brigid W. Cook is the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it.

This information is intended solely for the use of the Finance Committee and management of Nueces County Hospital District and is not intended to be and should not be used by anyone other than these specified parties.

Very truly yours,

COLLIER, JOHNSON & WOODS
A Professional Corporation

Brigid W Cook

Brigid W. Cook, CPA
Shareholder

RESPONSE:

This letter correctly sets forth the understanding of the Nueces County Hospital District.

Signed by: John Martinez

Title: Board Chair

Nueces County Hospital District
Combined Balance Sheet - All Fund Types & Account Groups
As of 9/30/2019
(In Whole Numbers)

UNAUDITED

	General Fund	Special Revenue Fund	Trust Fund	General Fixed Assets	General Long Term Debt	Total
Assets						
Cash & Cash Equivalents	44,286,732	34,579,009	142,330	0	0	79,008,070
Investments	0	20,991,212	0	0	0	20,991,212
Accrued Interest	0	48,189	239	0	0	48,428
Taxes Receivables, Net of Allowance	1,052,751	0	0	0	0	1,052,751
Other Receivables	3,341,365	0	0	0	0	3,341,365
Due from Other Funds	5,376	0	0	0	0	5,376
Prepaid Expenditures	131,001	0	0	0	0	131,001
Fixed Assets	0	0	0	32,116,594	0	32,116,594
Amt to be Provided for Retirement of LT Debt	0	0	0	0	31,634	31,634
Total Assets	48,817,224	55,618,410	142,568	32,116,594	31,634	136,726,430
Liabilities						
Accounts Payable	1,864,047	0	0	0	0	1,864,047
Accrued Payroll & Related Liabilities	204,099	0	0	0	0	204,099
Due to Other Funds	0	0	5,376	0	0	5,376
Deferred Revenue	1,052,751	0	0	0	0	1,052,751
Long Term Paid Time Off	0	0	0	0	31,634	31,634
Total Liabilities	3,120,897	0	5,376	0	31,634	3,157,907
Fund Equity						
Fund Balance	31,373,905	48,370,222	163,464	32,116,594	0	112,024,185
P&L Account	14,322,422	7,248,188	(26,272)	0	0	21,544,338
Total Fund Equity	45,696,327	55,618,410	137,192	32,116,594	0	133,568,523
Total Liabilities & Fund Equity	48,817,224	55,618,410	142,568	32,116,594	31,634	136,726,430

Nueces County Hospital District
Statement of Revenues and Expenditures - All Governmental and Trust Funds
General Fund
From 9/1/2019 Through 9/30/2019
(In Whole Numbers)

UNAUDITED

	Current Period Actual	Current Year Actual
Revenues		
Taxes	20,102	34,961,896
Penalties & Interest - Taxes	16,327	472,914
Spohn Corporate Member Revenue	8,213,798	108,186,992
Investment Income	89,705	1,268,316
Other Income	2,143	257,966
Total Revenues	8,342,075	145,148,084
Current Expenditures		
Intergovernmental Transfers	21,110,697	114,277,025
County Healthcare Funding	(2,418,103)	7,288,117
Salaries	89,859	1,155,129
Benefits	44,726	591,399
Legal & Professional Fees	68,031	799,255
Purchased Services	67,384	1,070,976
Supplies & Materials	2,267	16,713
Rent & Leases	10,521	127,695
Repairs & Maintenance	9	1,300
Utilities	3,051	34,735
Insurance	1,770	20,564
Administrative & General	8,507	50,225
Capital Outlay	42,798	80,528
Total Current Expenditures	19,031,516	125,513,662
Excess of Revenues Over Expenditures Before Sources/Uses	(10,689,441)	19,634,422
Other Financing Sources & Uses		
Operating Transfers In	0	(688,000)
Operating Transfers Out	6,000,000	6,000,000
Total Other Financing Sources & Uses	6,000,000	5,312,000
Excess of Revenues Over Expenditures After Sources & Uses	(16,689,441)	14,322,422
Fund Balance, Beginning of Year		31,373,905
FUND BALANCE, END OF YEAR		45,696,327

Nueces County Hospital District
Statement of Revenues and Expenditures - All Governmental and Trust Funds
Special Revenue Fund
From 9/1/2019 Through 9/30/2019
(In Whole Numbers)

UNAUDITED

	Current Period Actual	Current Year Actual
Revenues		
Investment Income	337,800	1,248,886
Tobacco Settlement Proceeds	0	687,302
Total Revenues	337,800	1,936,188
Excess of Revenues Over Expenditures Before Sources/Uses	337,800	1,936,188
Other Financing Sources & Uses		
Operating Transfers In	(6,000,000)	(6,000,000)
Operating Transfers Out	0	688,000
Total Other Financing Sources & Uses	(6,000,000)	(5,312,000)
Excess of Revenues Over Expenditures After Sources & Uses	6,337,800	7,248,188
Fund Balance, Beginning of Year		48,370,222
FUND BALANCE, END OF YEAR		55,618,410

UNAUDITED

Nueces County Hospital District
Statement of Revenues and Expenditures - All Governmental and Trust Funds
Trust Fund
From 9/1/2019 Through 9/30/2019
(In Whole Numbers)

	Current Period Actual	Current Year Actual
Revenues		
Investment Income	239	3,585
Total Revenues	239	3,585
Current Expenditures		
Benefits	5,376	28,425
Administrative & General	65	1,433
Total Current Expenditures	5,441	29,857
Excess of Revenues Over Expenditures Before Sources/Uses	(5,203)	(26,272)
Excess of Revenues Over Expenditures After Sources & Uses	(5,203)	(26,272)
Fund Balance, Beginning of Year		163,464
FUND BALANCE, END OF YEAR		137,192

Nueces County Hospital District
Statement of Revenues and Expenditures - Actual v. Budget
General Fund
From 9/1/2019 Through 9/30/2019
(In Whole Numbers)

UNAUDITED

	Current Period Actual	Current Period Budget	Current Period Budget Variance	Current Year Actual	YTD Budget	YTD Budget Variance
Revenues						
Taxes	20,102	0	20,102	34,961,896	32,704,041	2,257,855
Penalties & Interest - Taxes	16,327	30,448	(14,121)	472,914	327,040	145,874
Spohn Corporate Member Revenue	8,213,798	8,166,663	47,135	108,186,992	98,000,000	10,186,992
Investment Income	89,705	18,682	71,023	1,268,316	406,962	861,354
Other Income	2,143	0	2,143	257,966	300,000	(42,034)
Total Revenues	8,342,075	8,215,793	126,282	145,148,084	131,738,043	13,410,041
Current Expenditures						
Intergovernmental Transfers	21,110,697	23,292,287	2,181,590	114,277,025	117,018,192	2,741,167
County Healthcare Funding	(2,418,103)	984,390	3,402,493	7,288,117	11,786,629	4,498,512
Salaries	89,859	118,361	28,503	1,155,129	1,474,350	319,221
Benefits	44,726	57,115	12,389	591,399	714,782	123,383
Legal & Professional Fees	68,031	80,850	12,819	799,255	970,300	171,045
Purchased Services	67,384	79,464	12,080	1,070,976	1,203,950	132,974
Supplies & Materials	2,267	1,587	(680)	16,713	19,000	2,287
Rent & Leases	10,521	10,896	375	127,695	130,800	3,105
Repairs & Maintenance	9	626	617	1,300	7,600	6,300
Utilities	3,051	3,414	363	34,735	40,950	6,215
Insurance	1,770	2,121	351	20,564	25,500	4,936
Administrative & General	8,507	5,294	(3,213)	50,225	63,600	13,375
Capital Outlay	42,798	0	(42,798)	80,528	143,000	62,472
Extraordinary	0	413	413	0	5,000	5,000
Total Current Expenditures	19,031,516	24,636,818	5,605,302	125,513,662	133,603,653	8,089,991
Excess of Revenues Over Expenditures Before Sources/Uses	(10,689,441)	(16,421,025)	5,731,584	19,634,422	(1,865,610)	21,500,032
Other Financing Sources & Uses						
Operating Transfers In	0	0	0	(688,000)	(550,000)	138,000
Operating Transfers Out	6,000,000	6,000,000	0	6,000,000	6,000,000	0
Total Other Financing Sources & Uses	6,000,000	6,000,000	0	5,312,000	5,450,000	138,000
Excess of Revenues Over Expenditures After Sources & Uses	(16,689,441)	(22,421,025)	5,731,584	14,322,422	(7,315,610)	21,638,032
Fund Balance, Beginning of Year				31,373,905	0	31,373,905
FUND BALANCE, END OF YEAR				45,696,327	(7,315,610)	53,011,937

Nueces County Hospital District
Statement of Revenues and Expenditures - Actual v. Budget
Tobacco Settlement Fund
From 9/1/2019 Through 9/30/2019
(In Whole Numbers)

UNAUDITED

	Current Period Actual	Current Period Budget	Current Period Budget Variance	Current Year Actual	YTD Budget	YTD Budget Variance
Revenues						
Investment Income	1	0	1	836	0	836
Tobacco Settlement Proceeds	0	0	0	687,302	550,000	137,302
Total Revenues	1	0	1	688,138	550,000	138,138
Excess of Revenues Over Expenditures Before Sources/Uses	1	0	1	688,138	550,000	138,138
Other Financing Sources & Uses						
Operating Transfers Out	0	0	0	688,000	550,000	(138,000)
Total Other Financing Sources & Uses	0	0	0	688,000	550,000	(138,000)
Excess of Revenues Over Expenditures After Sources & Uses	1	0	1	138	0	138
Fund Balance, Beginning of Year				350	0	350
FUND BALANCE, END OF YEAR				488	0	488

Nueces County Hospital District
Statement of Revenues and Expenditures - Actual v. Budget
Indigent Care Fund
From 9/1/2019 Through 9/30/2019
(In Whole Numbers)

UNAUDITED

	Current Period Actual	Current Period Budget	Current Period Budget Variance	Current Year Actual	YTD Budget	YTD Budget Variance
Revenues						
Investment Income	337,799	50,400	287,399	1,248,050	541,587	706,463
Total Revenues	337,799	50,400	287,399	1,248,050	541,587	706,463
Excess of Revenues Over Expenditures Before Sources/Uses	337,799	50,400	287,399	1,248,050	541,587	706,463
Other Financing Sources & Uses						
Operating Transfers In	(6,000,000)	(6,000,000)	0	(6,000,000)	(6,000,000)	0
Total Other Financing Sources & Uses	(6,000,000)	(6,000,000)	0	(6,000,000)	(6,000,000)	0
Excess of Revenues Over Expenditures After Sources & Uses	6,337,799	6,050,400	287,399	7,248,050	6,541,587	706,463
Fund Balance, Beginning of Year				48,369,872	0	48,369,872
FUND BALANCE, END OF YEAR				55,617,922	6,541,587	49,076,335

Nueces County Hospital District
Combined Balance Sheet - All Fund Types & Account Groups
As of 10/31/2019
(In Whole Numbers)

UNAUDITED

	General Fund	Special Revenue Fund	Trust Fund	General Fixed Assets	General Long Term Debt	Total
Assets						
Cash & Cash Equivalents	55,728,319	29,651,693	142,509	0	0	85,522,521
Investments	0	25,991,611	0	0	0	25,991,611
Accrued Interest	0	71,031	207	0	0	71,238
Taxes Receivables, Net of Allowance	29,368,140	0	0	0	0	29,368,140
Other Receivables	3,341,365	0	0	0	0	3,341,365
Due from Other Funds	5,959	0	0	0	0	5,959
Prepaid Expenditures	115,821	0	0	0	0	115,821
Fixed Assets	0	0	0	32,116,594	0	32,116,594
Amt to be Provided for Retirement of LT Debt	0	0	0	0	31,634	31,634
Total Assets	88,559,604	55,714,335	142,716	32,116,594	31,634	176,564,883
Liabilities						
Accounts Payable	1,835,072	0	0	0	0	1,835,072
Accrued Payroll & Related Liabilities	232,549	0	0	0	0	232,549
Due to Other Funds	0	0	5,959	0	0	5,959
Deferred Revenue	29,368,140	0	0	0	0	29,368,140
Long Term Paid Time Off	0	0	0	0	31,634	31,634
Total Liabilities	31,435,761	0	5,959	0	31,634	31,473,354
Fund Equity						
Fund Balance	45,696,327	55,618,410	137,192	32,116,594	0	133,568,523
P&L Account	11,427,517	95,925	(436)	0	0	11,523,006
Total Fund Equity	57,123,844	55,714,335	136,757	32,116,594	0	145,091,529
Total Liabilities & Fund Equity	88,559,604	55,714,335	142,716	32,116,594	31,634	176,564,883

Nueces County Hospital District
Statement of Revenues and Expenditures - All Governmental and Trust Funds
General Fund
From 10/1/2019 Through 10/31/2019
(In Whole Numbers)

UNAUDITED

	Current Period Actual	Current Year Actual
Revenues		
Taxes	7,615,275	7,615,275
Penalties & Interest - Taxes	17,426	17,426
Spohn Corporate Member Revenue	6,413,965	6,413,965
Investment Income	76,470	76,470
Other Income	1,293	1,293
Total Revenues	14,124,430	14,124,430
Current Expenditures		
Intergovernmental Transfers	1,465,953	1,465,953
County Healthcare Funding	695,121	695,121
Salaries	109,770	109,770
Benefits	49,474	49,474
Legal & Professional Fees	214,623	214,623
Purchased Services	140,334	140,334
Supplies & Materials	1,301	1,301
Rent & Leases	11,459	11,459
Repairs & Maintenance	251	251
Utilities	3,150	3,150
Insurance	1,699	1,699
Administrative & General	3,776	3,776
Total Current Expenditures	2,696,913	2,696,913
Excess of Revenues Over Expenditures Before Sources/Uses	11,427,517	11,427,517
Excess of Revenues Over Expenditures After Sources & Uses	11,427,517	11,427,517
Fund Balance, Beginning of Year		45,696,327
FUND BALANCE, END OF YEAR		57,123,844

UNAUDITED

Nueces County Hospital District
Statement of Revenues and Expenditures - All Governmental and Trust Funds
Special Revenue Fund
From 10/1/2019 Through 10/31/2019
(In Whole Numbers)

	Current Period Actual	Current Year Actual
Revenues		
Investment Income	95,925	95,925
Total Revenues	95,925	95,925
Excess of Revenues Over Expenditures Before Sources/Uses	95,925	95,925
Excess of Revenues Over Expenditures After Sources & Uses	95,925	95,925
Fund Balance, Beginning of Year		55,618,410
FUND BALANCE, END OF YEAR		55,714,335

UNAUDITED

Nueces County Hospital District
Statement of Revenues and Expenditures - All Governmental and Trust Funds
Trust Fund
From 10/1/2019 Through 10/31/2019
(In Whole Numbers)

	Current Period Actual	Current Year Actual
Revenues		
Investment Income	207	207
Total Revenues	207	207
Current Expenditures		
Benefits	584	584
Administrative & General	59	59
Total Current Expenditures	643	643
Excess of Revenues Over Expenditures Before Sources/Uses	(436)	(436)
Excess of Revenues Over Expenditures After Sources & Uses	(436)	(436)
Fund Balance, Beginning of Year		137,192
FUND BALANCE, END OF YEAR		136,757

Nueces County Hospital District
Statement of Revenues and Expenditures - Actual v. Budget
General Fund
From 10/1/2019 Through 10/31/2019
(In Whole Numbers)

UNAUDITED

	Current Period Actual	Current Period Budget	Current Period Budget Variance	Current Year Actual	YTD Budget	YTD Budget Variance
Revenues						
Taxes	7,615,275	3,737,375	3,877,900	7,615,275	3,737,375	3,877,900
Penalties & Interest - Taxes	17,426	31,166	(13,740)	17,426	31,166	(13,740)
Spohn Corporate Member Revenue	6,413,965	7,041,667	(627,702)	6,413,965	7,041,667	(627,702)
Investment Income	76,470	30,322	46,148	76,470	30,322	46,148
Other Income	1,293	0	1,293	1,293	0	1,293
Total Revenues	14,124,430	10,840,530	3,283,900	14,124,430	10,840,530	3,283,900
Current Expenditures						
Intergovernmental Transfers	1,465,953	2,038,253	572,300	1,465,953	2,038,253	572,300
County Healthcare Funding	695,121	768,229	73,108	695,121	768,229	73,108
Salaries	109,770	113,460	3,690	109,770	113,460	3,690
Benefits	49,474	51,095	1,621	49,474	51,095	1,621
Legal & Professional Fees	214,623	175,842	(38,781)	214,623	175,842	(38,781)
Purchased Services	140,334	139,483	(851)	140,334	139,483	(851)
Supplies & Materials	1,301	1,617	316	1,301	1,617	316
Rent & Leases	11,459	11,091	(368)	11,459	11,091	(368)
Repairs & Maintenance	251	626	375	251	626	375
Utilities	3,150	3,545	395	3,150	3,545	395
Insurance	1,699	2,112	413	1,699	2,112	413
Administrative & General	3,776	5,324	1,548	3,776	5,324	1,548
Capital Outlay	0	123,000	123,000	0	123,000	123,000
Extraordinary	0	417	417	0	417	417
Total Current Expenditures	2,696,913	3,434,094	737,181	2,696,913	3,434,094	737,181
Excess of Revenues Over Expenditures Before Sources/Uses	11,427,517	7,406,436	4,021,081	11,427,517	7,406,436	4,021,081
Excess of Revenues Over Expenditures After Sources & Uses	11,427,517	7,406,436	4,021,081	11,427,517	7,406,436	4,021,081
Fund Balance, Beginning of Year				45,696,327	0	45,696,327
FUND BALANCE, END OF YEAR				57,123,844	7,406,436	49,717,408

Nueces County Hospital District
Statement of Revenues and Expenditures - Actual v. Budget
Tobacco Settlement Fund
From 10/1/2019 Through 10/31/2019
(In Whole Numbers)

UNAUDITED

	Current Period Actual	Current Period Budget	Current Period Budget Variance	Current Year Actual	YTD Budget	YTD Budget Variance
Revenues						
Investment Income	1	0	1	1	0	1
Total Revenues	1	0	1	1	0	1
Excess of Revenues Over Expenditures Before Sources/Uses	1	0	1	1	0	1
Excess of Revenues Over Expenditures After Sources & Uses	1	0	1	1	0	1
Fund Balance, Beginning of Year				488	0	488
FUND BALANCE, END OF YEAR				489	0	489

Nueces County Hospital District
Statement of Revenues and Expenditures - Actual v. Budget
Indigent Care Fund
From 10/1/2019 Through 10/31/2019
(In Whole Numbers)

UNAUDITED

	Current Period Actual	Current Period Budget	Current Period Budget Variance	Current Year Actual	YTD Budget	YTD Budget Variance
Revenues						
Investment Income	95,924	55,435	40,489	95,924	55,435	40,489
Total Revenues	95,924	55,435	40,489	95,924	55,435	40,489
Excess of Revenues Over Expenditures Before Sources/Uses	95,924	55,435	40,489	95,924	55,435	40,489
Excess of Revenues Over Expenditures After Sources & Uses	95,924	55,435	40,489	95,924	55,435	40,489
Fund Balance, Beginning of Year				55,617,922	0	55,617,922
FUND BALANCE, END OF YEAR				55,713,846	55,435	55,658,411

Materials for this agenda item will be distributed at the beginning of the meeting; the materials were not ready at the time the meeting packet was printed.

Bank of America
Merrill Lynch

Bank of America, N.A.
135 S. LaSalle Street, Suite 1840 Chicago, IL 60603

00172516

TEMP-RETURN SERVICE REQUESTED

MB 01 001374 74718 B 5 A

NUECES COUNTY HOSPITAL DISTRICT
ATTN: JONNY HIPP
555 NORTH CARANCAHUA ST. SUITE 950
CORPUS CHRISTI TX 78401-0835

Account Number	434372.1
Statement Period	11/01/2019 through 11/30/2019
Account Title	CHRISTUS SPOHN HEALTH SYSTEM CORP / NUECES COUNTY HOSPITAL DISTRICT CHRISTUS SPOHN / NUECES CNTY ESCROW

ADMINISTRATIVE OFFICER
13129923272

GCAS CLIENT SERVICE.
GCAS_AMRS_ESCROW_CLIENT_SERVICE@BAML.COM

ALTERNATE CONTACT
13129923272

CLIENT SERVICE.
GCAS_AMRS_ESCROW_CLIENT_SERVICE@BOFA.COM

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PARTICIPATING PORTFOLIOS

PORTFOLIO NUMBER	PORTFOLIO NAME
434372.1	CHRISTUS SPOHN / NUECES CNTY ESCROW

PARTICIPATING PORTFOLIOS

PORTFOLIO NUMBER	PORTFOLIO NAME

STATEMENT of INVESTMENT POSITION

QUANTITY	DESCRIPTION	COST/ AVG UNIT COST	MARKET VALUE/ PRICE	PROJECTED ANNUAL INCOME	YIELD
CASH AND EQUIVALENTS					
11,983,823.37	BLACKROCK TREASURY TRUST - CASH MANAGEMENT N4	11,983,823.37	11,983,823.37	120,519.45	
TOTAL CASH AND EQUIVALENTS		**11,983,823.37**	**11,983,823.37**	**120,519.45**	
	TOTAL ASSETS	**11,983,823.37**	**11,983,823.37**	**120,519.45**	

TRANSACTION SUMMARY

DESCRIPTION	INCOME CASH	PRINCIPAL CASH	COST
BEGINNING BALANCE	**0.00**	**0.00**	**11,971,185.86**
DIVIDENDS	0.00	0.00	0.00
INTEREST	0.00	12,637.51	0.00
OTHER INCOME	0.00	0.00	0.00
RECEIPTS & DEPOSITS	0.00	0.00	0.00
SALES & DISPOSITIONS	0.00	0.00	0.00
INTRA ACCOUNT TRANSFERS	0.00	0.00	0.00
DISTRIBUTIONS & WITHDRAWALS	0.00	0.00	0.00
PURCHASES & ACQUISITIONS	0.00	-12,637.51	12,637.51
FEES & EXPENSES	0.00	0.00	0.00
MISCELLANEOUS	0.00	0.00	0.00
ENDING BALANCE	**0.00**	**0.00**	**11,983,823.37**

DATE	DESCRIPTION	INCOME CASH	PRINCIPAL CASH	COST
	BEGINNING BALANCE	**0.00**	**0.00**	**11,971,185.86**
11/01/19	INTEREST PAYMENT PAYABLE 11/01/19 BLACKROCK TREASURY TRUST - CASH MANAGEMENT N4		12,637.51	
11/01/19	SWEEP PURCHASE 12,637.51 SHARES TRADE 11/01/19 BLACKROCK TREASURY TRUST - CASH MANAGEMENT N4		-12,637.51	12,637.51
	ENDING BALANCE	**0.00**	**0.00**	**11,983,823.37**

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Please note the important regulatory disclosures which are accessible at the following website:

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This website address appears at the foot of your reports and statements for your convenience.

Cash Sweep Clients

With respect to any "cash sweep vehicle", if applicable, Money Market Funds and Mutual Funds are not deposits within the meaning of the Federal Deposit Insurance Act (12 U.S.C. 1813 (l)), are not insured or guaranteed by the U.S. Government, the FDIC or any other government agency, are not insured, endorsed or guaranteed by Bank of America, are not obligations of Bank of America, and involve investment risk, including possible loss of principal. If a receiver were appointed for Bank of America, the client would have an ownership interest in the shares of the Money Market Fund or the Mutual Fund that Bank of America purchased on behalf of the client.

Materials for this agenda item will be distributed at the beginning of the meeting; the materials were not ready at the time the meeting packet was printed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 430, 433, 447, 455, and 457

[CMS–2393–P]

RIN 0938–AT50

Medicaid Program; Medicaid Fiscal Accountability Regulation

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would promote transparency by establishing new reporting requirements for states to provide CMS with certain information on supplemental payments to Medicaid providers, including supplemental payments approved under either Medicaid state plan or demonstration authority, and applicable upper payment limits. Additionally, the proposed rule would establish requirements to ensure that state plan amendments proposing new supplemental payments are consistent with the proper and efficient operation of the state plan and with efficiency, economy, and quality of care. This proposed rule addresses the financing of supplemental and base Medicaid payments through the non-federal share, including states' uses of health care-related taxes and bona fide provider-related donations, as well as the requirements on the non-federal share of any Medicaid payment.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 17, 2020.

ADDRESSES: In commenting, please refer to file code CMS–2393–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2393–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2393–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Andrew Badaracco, (410) 786–4589, Richard Kimball, (410) 786–2278, and Daniil Yablochnikov, (410) 786–8912, for Medicaid Provider Payments, Supplemental Payments, Upper Payment Limits, Provider Categories, Intergovernmental Transfers, and Certified Public Expenditures.

Timothy Davidson, (410) 786–1167, Jonathan Endelman, (410) 786–4738, and Stuart Goldstein, (410) 786–0694, for Health Care-Related Taxes, Provider-Related Donations, and Disallowances.

Lia Adams, (410) 786–8258, Charlie Arnold, (404) 562–7425, Richard Cuno, (410) 786–1111, and Charles Hines, (410) 786–0252, for Medicaid Disproportionate Share Hospital Payments and Overpayments.

Jennifer Clark, (410) 786–2013, and Deborah McClure, (410) 786–3128, for Children's Health Insurance Program (CHIP).

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments.

I. Background

A. Overview

Title XIX of the Social Security Act (the Act) established the Medicaid program as a federal-state partnership for the purpose of providing and financing medical assistance to specified groups of eligible individuals. States have considerable flexibility in designing their programs, but must abide by requirements specified in the federal Medicaid statute and regulations. Each state is responsible for administering its Medicaid program in accordance with an approved state plan, which specifies the scope of covered services, groups of eligible individuals, payment methodologies, and all other information necessary to assure the state plan describes a comprehensive and sound structure for operating the Medicaid program, and ultimately, provides a clear basis for claiming federal matching funds.

As discussed in more detail below, the goal of this proposed rule is to strengthen overall fiscal integrity of the Medicaid program. The proposed rule focuses on four topic areas that are frequently discussed as program vulnerabilities by federal oversight authorities, including the Government Accountability Office (GAO), the Department of Health and Human Services' Office of Inspector General (OIG), and the Medicaid and CHIP Payment and Access Commission (MACPAC). These topics include: Medicaid fee-for-service (FFS) provider payments; disproportionate share hospital (DSH) payments; Medicaid program financing; supplemental payments; and health care-related taxes and provider-related donations. Due to the complex nature of these topic areas, we have organized this proposed rule to separately discuss each topic and describe the programmatic concerns that we seek to address through this proposed rule. However, the proposed provisions would rely on similar strategies to improve our and states' abilities to oversee fiscal integrity by requiring transparency through better data reporting, clarifying regulatory payment and financing definitions, refining administrative procedures used by states to comply with federal regulations, clarifying regulatory language that could be subject to misinterpretation, and removing regulatory requirements that have been difficult to administer and do not further our oversight objectives. As a result, the provisions of the proposed rule aim to address multiple topic areas as part of the overall strategy to improve fiscal integrity.

While some of the proposed policies are new, there are policies within the proposed rule that CMS has operationalized through our work with states and interpretations of the statute in subregulatory guidance and federal regulations. We have implemented this subset of policies using existing legal authority. Some of the proposed policies in the proposed rule, such as the non-bona fide provider related donations provisions, have been reviewed and upheld by the Departmental Appeals Board (DAB) and the courts. Therefore, we are clarifying the regulatory language

in this proposed rule that may have been subject to misinterpretation by states and other stakeholders, or that otherwise could benefit from additional specificity. In these cases, as discussed below, we are not proposing new statutory interpretations, but are merely proposing to codify existing policies into the Code of Federal Regulations (CFR) to improve guidance to states and other stakeholders and, to the extent possible, help prevent states from implementing policies that do not comport with applicable statutory requirements.

B. General Information on Certain Medicaid Financial Topics Addressed in This Proposed Rule

1. Medicaid FFS Provider Payments

a. General Background

States are responsible for developing FFS rates to pay providers for furnishing health care services to beneficiaries who receive covered services through the FFS delivery system. In recognition of the states' front line responsibility, the statute affords states considerable flexibility by not prescribing any particular rate setting approach or method (for most Medicaid services), but instead allows states to develop their own approaches unique to their local circumstances so long as they are consistent with applicable statutory requirements and provide the public and interested parties an opportunity to comment and offer input. In particular, section 4711 of the Balanced Budget Act of 1997 (BBA 97) (Pub. L. 105–33, enacted August 5, 1997) amended section 1902(a)(13)(A) of the Act to give states greater flexibility to develop their own payment methods and standards by replacing prescriptive rate setting requirements with the present standard that rates for inpatient hospital, nursing facility, and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services be established in accordance with a public process. The public process emphasizes transparency in how states approach rate setting by providing stakeholders with a reasonable opportunity to review and comment on the proposed FFS rates, rate setting methodologies, and justifications before states publish final rates, underlying methodologies, and justifications. However, it does not impose any constraints on states with respect to the payment methodologies they may wish to adopt to purchase Medicaid services.

Similarly, states are free to develop their own approach to establishing payment rates for other Medicaid services and, under longstanding regulations at § 447.205, generally must publish public notice in advance to implement new, or change existing, methods and standards for setting payment rates for services. For example, states may decide to use a prospective payment or a retrospective payment system and may elect to reimburse on a per unit, per day, or per discharge basis. Whatever payment methodology or system a state elects to implement, the state must describe the methodology or system comprehensively in its Medicaid state plan and submit the proposed methodology to CMS for review and approval in a manner consistent with 42 CFR part 430, subpart B.

State payment methodologies typically provide for a standard payment to all Medicaid providers on a per claim basis for services rendered to a Medicaid beneficiary in a FFS environment. We refer to these payments as ''base payments.'' Base payments also include any payment adjustments, add-ons, or other additional payments received by the provider that can be attributed to services identifiable as having been provided to an individual beneficiary, including those that are made to account for a higher level of care or complexity or intensity of services provided to an individual beneficiary.

Having established a base payment system, states may wish to offer extra compensation to certain providers by establishing supplemental payments within the state's overall approach to reimbursing Medicaid providers. ''Supplemental payments'' are payments made to providers that are in addition to the base payment the provider receives for services furnished. They can be directed to all providers or directed to a designated set of providers, with the amount of the payment depending upon applicable upper payment limit (UPL) demonstration requirements in §§ 447.272 and 447.321 for inpatient and outpatient settings, respectively. Unlike base FFS payments, which are directly attributable to a covered service furnished to an individual beneficiary, supplemental payments are often made to the provider in a lump sum on a monthly, quarterly, or annual basis apart from payments for a provider claim, and therefore, cannot be directly linked to a provider claim for specific services provided to an individual Medicaid beneficiary. Effectively, the supplemental payments serve to increase total Medicaid payments to a provider for all Medicaid services furnished over a set period of time as shown in the state's UPL demonstration. The UPL demonstration is the means by which the state documents that the Medicaid payments for the applicable services are below the aggregate UPL amount. In general, supplemental payments are recognized as service payments as they supplement base payments previously made to purchase Medicaid services from providers. Typically, they are made under FFS state plan authority but, more recently, states have made similar types of payments through demonstration and managed care authorities.

As discussed previously, for most services, the Medicaid statute does not prescribe a particular payment approach; however, the statute does contemplate that states will be prudent purchasers of health care services. More specific to rate setting, section 1902(a)(30)(A) of the Act requires states to have methods and procedures to assure Medicaid payments for services, including any base and supplemental payments, are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. Under section 1902(a)(30)(A) authority, implementing federal regulations establish UPLs for certain services and rely on these limits to help assure that state Medicaid payments are consistent with ''efficiency and economy.'' Federal financial participation (FFP) is not available for state Medicaid expenditures that exceed an applicable UPL.

Medicaid UPLs are codified in regulations at §§ 447.272 and 447.321 and apply to payments for Medicaid inpatient hospital, nursing facility and ICF/IID services, as well as for outpatient hospital and clinic services. For each of these Medicaid benefits, the UPLs are first constructed by categorizing providers into groups (''ownership groups'') according to the ownership or operational interests: State government-owned or operated, non-state government-owned or operated, and privately-owned and operated. States are restricted, in the aggregate for each ownership group, from paying more than a reasonable estimate of the amount Medicare would pay for the services furnished by the providers in the applicable ownership group. The aggregate application of these UPLs has preserved state flexibility for setting facility-specific payments while creating an overall payment ceiling as a mechanism for determining economy and efficiency of payment for the

services described above, consistent with section 1902(a)(30)(A) of the Act.

Where Medicaid base payments are below the aggregate UPL calculation, states have the ability to make supplemental payments to providers, by ownership group, up to the calculated limit. With the aggregate UPL calculations, states have the ability to pay some providers in excess of a reasonable amount that Medicare would pay those individual providers for their services furnished, so long as the aggregate Medicaid payments are less than or equal to the aggregate UPL amount for the ownership category. Should states wish to make payments up to the UPL and have the non-federal share available to do so, after giving public notice, they may modify their state plan payment methodologies to provide for supplemental payments. We note that, without a regulatory standard to govern UPLs for practitioner services, CMS has allowed states to make Medicaid supplemental payments for practitioner services up to Medicare payment amounts or, based on data documentation, up to the average commercial rate (ACR) made to providers. As discussed later in this proposed rule, ACRs are payments developed using the average of some commercial payers' payment rates for medical services to establish a supplemental Medicaid rate for certain practitioners, typically physicians, under the state plan. Unlike other supplemental payments subject to UPLs, some of these practitioner supplemental payments have resulted in payments to providers in excess of a reasonable estimate of what Medicare would have paid for the services furnished, as the relevant ACRs generally are higher than Medicare rates. This result is possible because there currently is no UPL applicable to payments for practitioner services based on a reasonable estimate of what Medicare would pay.

Under our current UPL regulations and CMS policy, approval of a supplemental payment is not an indication that a state's proposal to use supplemental payments within its payment system is the best approach to setting Medicaid payments. Instead, our approvals have been based on the state's documentation of UPL calculations, where applicable, showing that the total Medicaid payments (base and supplemental) paid to providers under the state plan are within the federal limits. Beyond that test and a review of state plan amendments (SPAs) which propose to add or amend supplemental payment methodologies or aggregate supplemental payments, we have not closely examined how states distribute Medicaid payments to individual providers as a matter of routine oversight.

Through the policies proposed in this proposed rule, we are seeking to better understand the relationship between and among the following: Supplemental provider payments, costs incurred by providers, current UPL requirements, state financing of the non-federal share of supplemental payments, and the impact of supplemental payments on the Medicaid program (such as improvements in the quality of, or access to, care). It often appears to us that most of these payment methodologies do not result in an equitable distribution of payments to improve adequacy of rates across providers within the service class or ownership group, or otherwise improve the Medicaid program in some measurable, value-added way. Instead, many supplemental payment strategies appear to target only those providers that can participate in financing the non-federal share funding required to support a state's claim for FFP. In certain circumstances, this practice may be inconsistent with section 1902(a)(2) of the Act, which requires states to assure that a lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan, since the payments are only available to providers with the means to provide the non-federal share.

For instance, states might use the entire UPL gap (the difference between the amounts paid in base payments and the aggregate UPL) for each service type and provider ownership group to make a supplemental payment to only a small subset of providers in the group. In an example of this type of supplemental payment structure, one state implemented an inpatient hospital supplemental payment methodology to make payments up to the UPL for non-state government operated hospitals. The supplemental payment was funded by intergovernmental transfers (IGTs) from a local (city) government. Although the total amount of the supplemental payment was based on the available UPL room for 26 non-state government operated hospitals, under the terms of the methodology, only three hospitals qualified to receive the supplemental payment. This resulted in total payments to those three hospitals that far exceeded their reported total cost incurred for all Medicaid services, which is inconsistent with section 1902(a)(30)(A) of the Act.

Supplemental payments now comprise a large and growing percentage of total Medicaid payments. They are commonly paid both to institutional providers (for example, inpatient hospitals, nursing facilities, and ICF/IIDs) and for outpatient services (for example, outpatient hospitals, clinics, and physician services). Currently, 48 states reported using at least one type of supplemental payment methodology under the Medicaid state plan. As a percentage of total Medicaid payments for institutional providers, data from the Medicaid Budget and Expenditure System (MBES) indicate that supplemental payments have steadily increased from 9.4 percent in FY 2010, the first year in which states separately reported these payments, to 17.5 percent of all FFS payments to hospitals, nursing facilities, ICF/IIDs, and physician service payments in FY 2017. Supplemental payments to providers under demonstration authority, which can allow additional flexibility to cover beneficiaries and services not usually permitted under state plan authority, have also grown. In December 2018, MACPAC released the ''Medicaid Inpatient Hospital Services Fee-for Service Payment Policy'' issue brief where it noted that expenditures for hospital UPL supplemental payments increased from 2 to 3 percent of total expenditures for Medicaid benefits between 2001 and 2016.[1] In the MACPAC analysis, the totality of supplemental payments, DSH payments, and uncompensated care payments made under demonstration authority, as a share of the total computable Medicaid payments to hospitals in FY 2016, was 27 percent. In all, the MACPAC analysis concluded that the total expenditures in 2016 for DSH payments were $16.5 billion, for UPL supplemental payments were $16.4 billion, and for uncompensated care payments were $8.5 billion.

b. Current CMS Review of Provider Payments and Oversight Concerns

The Medicaid statute and regulations require states to report program-related information to CMS regarding their payment methodologies and incurred expenditures that are claimed for federal matching funds. Section 1902(a)(6) of the Act requires the Medicaid agency to make reports as the Secretary of Health and Human Services (the Secretary) may require and to comply with provisions the Secretary finds necessary to assure the correctness and verification of such reports. Implementing regulations at 42 CFR 431.107(b) require states to ensure that providers maintain auditable

[1] *https://www.macpac.gov/wp-content/uploads/2016/03/Medicaid-Inpatient-Hospital-Services-Fee-for-Service-Payment-Policy.pdf.*

documentation of the services furnished to beneficiaries for which the state makes program expenditures and claims FFP, to allow the federal government to ensure that all applicable federal requirements are met. Additionally, 42 CFR 430.30(c) requires states to submit the Form CMS–64, which is a quarterly accounting statement of the state's actual recorded expenditures that serves as the primary basis for Medicaid payments to states under section 1903(a)(1) of the Act.

The primary means to collect information on Medicaid program eligibility, services, and expenditures has historically been through CMS' Medicaid Statistical Information System (MSIS), which is populated by FFS claims and managed care encounter data from states' Medicaid Management Information Systems (MMIS), which are an integrated group of procedures and computer processing operations (sub-systems) developed at the general design level to meet principal objectives, and CMS' MBES, which is the system through which states file quarterly Medicaid expenditures on the Form CMS–64. These systems have been essential to both the states and the federal government in operating Medicaid and provide valuable program information. However, neither the modern Transformed Medicaid Statistical Information System (T–MSIS), which has replaced MSIS, discussed further below, nor MBES, separately or together, provides the level of detail on the payment and financing of supplemental payments necessary to effectively monitor and evaluate the use and impact of those payments.

MSIS is an eligibility and claims data set that provides a summary of services and payments linked to specific beneficiaries on the basis of claims submitted to the states by providers. However, the MSIS data include very little information about the providers furnishing services. In addition, MSIS is unable to capture the providers' supplemental payments since those payments are not directly tied to specific beneficiaries, but rather, typically, are made based on the volume of Medicaid services rendered and generally are paid to providers as lump sums, separately from payments for service claims. Another often cited problem with MSIS data is that, in spite of regulations requiring timely reporting, there is generally a considerable time lag between when the services are paid for by the state and when data on those payments is furnished to CMS through MSIS.

To improve the completeness and timeliness of such data for the purposes of program monitoring and oversight, we currently are working with states to collect more robust data through an expansion and update of MSIS, which is referred to as the T–MSIS. T–MSIS data improves our ability to study utilization patterns and trends, identify high cost and high needs populations, analyze expenditures by category of service and provider type, monitor enrollment and expenditures within delivery systems, assess the impact of different types of delivery system models on beneficiary outcomes, and examine access to care issues. However, although we are currently working to improve T–MSIS' reporting capability for supplemental payments, T–MSIS will not capture supplemental payments at the level of detail proposed under this proposed rule. It should be noted that T–MSIS is capable of capturing the non-federal share of base rate payments. Currently, there are significant gaps in state reporting related to this particular data element, which we also are working with states to correct.

MBES data include all state expenditures filed on the Form CMS–64. The Form CMS–64 is a summary of a state's actual Medicaid expenditures, for both state program administration and medical assistance (that is, payments for services furnished to beneficiaries), derived from source documents including invoices, payment vouchers, governmental funds transfers, expenditure certifications, cost reports and settlements, and eligibility records. This form shows the disposition of Medicaid grant funds for the quarter being reported and any prior period adjustments. It also accounts for any overpayments, underpayments, refunds received by the state Medicaid agency, and income earned on grant funds. With limited exceptions, MBES does not contain beneficiary, provider, or claim-level information for the reported expenditures, including supplemental payments. We can only obtain such information by requesting separate supporting documentation from the state. Attempting to improve oversight and transparency of supplemental payments, we added expenditure reporting lines in MBES in 2010 for states to separately report the amounts of supplemental payments made for various types of services. This information is reported at the aggregate service level and does not include details on which providers receive those payments, the specific amount received by each, or the source of the non-federal share that supports those expenditures. While this reporting requirement slightly improved transparency, there were large variations in the total payment amounts reported through MBES and the total payment amounts through UPL demonstrations and we are concerned that state reporting has not always been complete and accurate and should be improved.

We also gather information on the nature and extent of proposed supplemental payments during our review of SPAs. As part of the documentation submitted with payment-related SPAs, states must describe which providers would be eligible for the payments and how the payments would be calculated and distributed, provide an estimate of the fiscal impact, and disclose the source of the non-federal share of the proposed expenditures. The opportunity to evaluate the permissibility and potential impact of supplemental payments is presented when a state submits a proposal. Current regulations do not contemplate that, once we have approved a SPA, as described in part 430, subpart B, we would routinely monitor the implementation and effects of the SPA in a formal, systematic way. The opportunity to review state payments after the agency has approved a SPA generally is limited to the submission of SPAs to update or change the supplemental payment methodology. Our other mechanisms for review are financial management reviews and audits of state programs which may cover any area of the Medicaid program and require advanced planning and are resource intensive for CMS and states. We also have relied upon reviews conducted by other government oversight bodies. These reviews are often resource intensive and require a large amount of data sharing, consultation, discussions, and policy reviews. As such, many years may pass before we are able to finalize the reviews and revisit supplemental payment methodologies, either through financial management review or the submission of a SPA. Because of this, we are unable to periodically evaluate these payment arrangements, including individual underlying provider payment amounts, to determine if the payments have been consistent with economy, efficiency, quality, access, and appropriate utilization, as required by statute. We do not generally collect further information associated with a SPA in a centralized manner, and such information generally is not presented at the provider level.

In its March 2014 *Report to the Congress on Medicaid and CHIP,* MACPAC noted that supplemental payments to hospitals, according to their analysis of supplemental payments

in 5 states, accounted for more than 20 percent of total computable Medicaid FFS payments to hospitals in those 5 states, and in some states account for more than 50 percent of such payments.[2] MACPAC has recommended that the Secretary collect provider-level data on supplemental payments to, among other things, provide greater transparency regarding Medicaid payments and facilitate assessments of Medicaid payments and analysis of the relationship between supplemental payments and access to care, as well as the economy and efficiency of Medicaid payments. In developing this proposed rule, we also considered the findings reported by MACPAC in the March 2012 *Report to the Congress on Medicaid and CHIP,* which identified data limitations regarding lump-sum Medicaid supplemental payments as an impediment to comparing payment levels across providers and states, determining the total amount of Medicaid spending on specific services and populations, and evaluating the impact of Medicaid payment policies.[3]

Without complete provider-level payment information, we do not have sufficient information to evaluate whether rate methodologies result in payments within a service type and provider ownership group that are economic and efficient as required under section 1902(a)(30)(A) of the Act. The GAO has issued a series of reports which note that the lack of reliable CMS data about Medicaid payments to providers and state financing of the non-federal share hinders our ability to adequately oversee the Medicaid program. To help ensure that each state meets the statutory and regulatory requirements regarding its oversight responsibilities, data reporting, and financial participation, the GAO has recommended that regulatory and legislative efforts be strengthened. Specific to Medicaid supplemental payments, the GAO has had longstanding concerns regarding the need for improved transparency and accountability. For example, in 2015, the GAO issued a report entitled, ''Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy,'' that stated, ''[w]ithout good data on payments to individual providers, a policy and criteria for assessing whether the payments are economical and efficient, and a process for reviewing such payments, the federal government could be paying states hundreds of millions, or billions, more than what is appropriate.'' [4] As a result, the GAO has recommended that to better ensure the fiscal integrity of the program, we should establish financial reporting at a provider-specific level and clarify permissible methods for calculating Medicaid supplemental payment amounts.

Since the availability of FFS supplemental payments under the aggregate UPL is driven by the volume of services provided through the FFS system, a shift to managed care or certain demonstration projects results in a lowered UPL estimate and a corresponding decrease in the level of FFS supplemental payments that a state can make. For example, there are instances when pool payments established through a demonstration authorized under section 1115(a) of the Act pay for uncompensated care costs for the provision of health care services to Medicaid beneficiaries, the underinsured, and the uninsured, or for state projects that promote delivery system reforms. States have also authorized pass-through payments or incentive arrangements to providers under managed care contracts that can operate similarly to existing FFS supplemental payments. We have authorized these payments within certain requirements described in 42 CFR part 438 and demonstration terms and conditions, as applicable, noting that the financing requirements in 42 CFR parts 430 and 433 and addressed in this proposed rule are applicable to FFS, managed care, and demonstration authorities.

Given the growing prevalence of supplemental payments and concerns raised by federal oversight agencies, we are concerned that our past practice of basing approval of SPAs regarding supplemental payments primarily on aggregate UPL compliance does not provide us with sufficient information to adequately ensure that supplemental payments are consistent with statutory requirements for economy and efficiency, quality of care, and access, or otherwise with sound program management principles. As a result, as discussed in greater detail in section II. of this proposed rule, the Provisions of the Proposed Rule section, we are proposing to gather additional information to better understand how states distribute supplemental payments to individual providers and whether there are benefits to the Medicaid program resulting from the supplemental payments.

2. Disproportionate Share Hospital (DSH) Payments

a. Background

States have statutory authority to make DSH payments to qualifying hospitals. Section 1902(a)(13)(A)(iv) of the Act requires that states take into account the situation of hospitals that serve a disproportionate share of low-income patients with special needs, in a manner consistent with section 1923 of the Act. These are not considered part of the base rate payments or supplemental payments, as they are made under distinct statutory authority. Section 1923 of the Act contains specific requirements related to DSH payments, including aggregate annual state-specific DSH allotments that limit FFP for statewide total DSH payments under section 1923(f) of the Act, and hospital-specific limits on DSH payments under section 1923(g) of the Act. Under the hospital-specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing inpatient and outpatient hospital services during the year to Medicaid beneficiaries and the uninsured, less payments received from or on behalf of the Medicaid beneficiaries or uninsured patients. In addition, section 1923(a)(2)(D) of the Act requires states to provide an annual report to the Secretary describing the DSH payment adjustments made to each DSH.

Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted December 8, 2003) added section 1923(j) of the Act to require states to report additional information about their DSH programs. Section 1923(j)(1) of the Act requires states to submit an annual report including an identification of each DSH that received a DSH payment adjustment during the preceding fiscal year (FY) and the amount of such adjustment, and such other information as the Secretary determines necessary to ensure the appropriateness of the DSH payment adjustments for such fiscal year. Additionally, section 1923(j)(2) of the Act requires states to submit an independent certified audit of the state's DSH program, including specified content, annually to the Secretary.

[2] Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP, March 14, 2014,* 184 (2014), *https://www.macpac.gov/wp-content/uploads/2015/01/2014-03-14_Macpac_Report.pdf.*

[3] Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP, March 15, 2012,* 167 (2012), *https://www.macpac.gov/wp-content/uploads/2015/01/State_Approaches_for_Financing_Medicaid_and_Update_on_Federal_Financing_of_CHIP.pdf.*

[4] U.S. Gov't Accountability Office, GAO–15–322, Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy, 46 (2015), *https://www.gao.gov/assets/670/669561.pdf.*

b. Concerns Raised Regarding Overpayments Identified Through Annual DSH Audits

The ''Medicaid Program; Disproportionate Share Hospital Payments'' final rule published in the December 19, 2008 **Federal Register** (73 FR 77904) (and herein referred to as the 2008 DSH audit final rule) requires state reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the hospital-specific DSH limits under section 1923(g) of the Act.

The regulations at 42 CFR part 455, subpart D, implement section 1923(j)(2) of the Act. FFP is not available for DSH payments that are found in the independent certified audit to exceed the hospital-specific limit. Amounts in excess of the hospital-specific limit are regarded as overpayments to providers, under 42 CFR part 433, subpart F. The discovery of overpayments necessitates the return of the federal share or redistribution by the state of the overpaid amounts to other qualifying hospitals, in accordance with the state's approved Medicaid state plan. The regulations in part 433, subpart F provide for refunding of the federal share of Medicaid overpayments paid to providers. While the preamble to the 2008 DSH audit final rule generally addressed the return or redistribution of provider overpayments identified through DSH audits, it did not include specific procedural requirements for returning or redistributing overpayments. As described below, we are proposing to incorporate into regulation procedural requirements associated with the return and redistribution of DSH overpayments.

While the information included in the independent certified audits and associated reports provides CMS and states with robust data, we are often unable to determine whether a DSH overpayment to a provider has occurred, the root causes of any overpayments, and the amount of the overpayments associated with each cause. Despite the robust data, potential data gaps may exist as a result of an auditor identifying an area, or areas, in which documentation is missing or unavailable for certain costs or payments that are required to be included in the calculation of the total eligible uncompensated care costs. Therefore, in current practice, an auditor may include a finding (or ''caveat'') in the audit stating that the missing information may impact the calculation of total eligible uncompensated care costs, instead of making a determination of the actual financial impact of the identified issue. This lack of transparency results in uncertainty and restricts CMS' and states' ability to ensure proper recovery of all FFP associated with DSH overpayments identified through annual DSH audits. For example, an audit may identify that a hospital was unable to satisfactorily document the outpatient services it provided to Medicaid-eligible patients, indicating that charges and payments were not included in the DSH uncompensated care calculation. Based on this lack of documentation, the audit includes a caveat of its finding indicating that the hospital's uncompensated care cost may be misstated as a result of this exclusion and that the impact is unknown. Given this lack of quantification of the financial impact of this finding, we are unable to determine whether an overpayment, if any, has resulted from this audit finding. To obtain such information, either CMS and/or the state would have to conduct a secondary review or audit, which would be burdensome and largely redundant. Specifically, conducting a secondary review or audit after the independent auditors have completed theirs would lengthen the review process, and therefore, delay the results of the audit. It would also require additional time, personnel, and resources by CMS, states, and hospitals to participate in a secondary review or audit.

The OIG and GAO have raised concerns similar to ours with respect to our ability to adequately oversee the Medicaid DSH program. Specifically, the OIG published the report, ''Audit of Selected States' Medicaid Disproportionate Share Hospital Programs'' in March 2006,[5] in which the OIG recommended that we establish regulations requiring states to implement procedures to ensure that future DSH payments are adjusted to actual incurred costs, incorporate these adjustment procedures into their approved state plans, and include only allowable costs as uncompensated care costs in their DSH calculations. The 2008 DSH audit final rule addressed the concerns raised by the OIG in regulations implementing the independent certified audit requirements under section 1923(j) of the Act, by requiring states to include data elements as specified in § 447.299(c) with their annual audits. In 2012, the GAO published the report, ''Medicaid: More Transparency of and Accountability for Supplemental Payments are Needed,'' [6] in which the GAO examined how information on DSH audits facilitates our oversight of DSH payments. In the report, GAO analyzed the 2010 DSH audits submitted by states. Of the 2,953 audits submitted to CMS, 228 had data reliability or documentation issues that inhibited the auditor's ability to determine compliance with DSH audit requirements. While the independent certified audit requirements have allowed us to identify various compliance issues and quantify some provider overpayments, in some instances, audits have identified issues related to incomplete or missing data and have failed to make a determination regarding the financial impact of these issues. Therefore, we have identified this area as an opportunity to strengthen program oversight and integrity protections, specifically with respect to the overpayment and redistribution reporting process and requirements for identifying the financial impact of audit findings. In proposing an additional data element, as discussed below, we hope to further enhance our oversight to better ensure the integrity of hospital-specific limit calculations.

The new data element we are proposing to add to annual DSH reporting would require auditors to quantify the financial impact of any finding, including those resulting from incomplete or missing data, which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit. We believe that requiring the quantification of these findings would limit the burden on both states and CMS of performing follow-up reviews or audits and will help ensure appropriate recovery and redistribution, as applicable, of all DSH overpayments.

To enhance federal oversight of the Medicaid DSH program and improve the accuracy of DSH audit overpayments identified and collected through annual DSH audits, we are also proposing to require states to report overpayments identified through annual DSH audits and related payment redistributions on the Form CMS–64 in a timely and transparent manner. Specifically, we propose to clarify the reporting requirement for overpayments identified through the annual DSH audits at § 447.299(f), by directing states to return payments in excess of hospital-specific cost limits to the federal government by reporting the excess amount on Form CMS–64, as a decreasing adjustment. We are proposing to require states to report these decreasing adjustments to

[5] Audit of Selected States' Medicaid Disproportionate Share Hospital Programs,'' March 2006 (A–06–03–00031), *https://www.oig.hhs.gov/oas/reports/region6/60300031.pdf.*

[6] *https://www.gao.gov/assets/660/650322.pdf.*

correspond with the fiscal year DSH allotment on the Form CMS–64. Additionally, we are proposing to establish reporting requirements on the redistribution of DSH overpayments, as determined under § 447.299(g) of this chapter in accordance with a redistribution methodology in the approved Medicaid state plan. We propose to require states to report the redistribution of DSH overpayments to correspond with the fiscal year DSH allotment and Medicaid state plan rate year, on the Form CMS–64. This proposal memorializes our redistribution policy in regulations and enhances proper oversight. We are proposing that overpayment amounts be redistributed within 2 years from the date of discovery, as proposed under § 447.299(g).

c. Modernizing the Publication of Annual DSH Allotments

Section 447.297 provides a process and timeline for CMS to publish preliminary and final annual DSH allotments and national expenditure targets in the **Federal Register**. The current requirements specify that we publish DSH allotments and national expenditure targets, in preliminary and final formats, by October 1st (preliminary target and allotments) and April 1st (final target and allotments) of each federal fiscal year. We have found the current regulatory **Federal Register** publication process to be time consuming and administratively burdensome and are concerned that the information is not available to states and other interested parties in a timely and easily accessible manner. In this proposed rule, we propose to make allotment and national expenditure targets available more timely by posting the information on *Medicaid.gov* and in MBES, or its successor website or system, instead of publishing this information in the **Federal Register**.

3. Medicaid Program Financing

a. Background

Medicaid expenditures are jointly funded by the federal and state governments. Section 1903(a)(1) of the Act provides for payments to states of a percentage of medical assistance expenditures authorized under the approved state plan. FFP is available when there is a covered Medicaid service provided to a Medicaid beneficiary, which results in a federally matchable expenditure that is funded in part through non-federal funds from the state or a non-state governmental entity (except when the statute provides a 100 percent federal match rate for specified expenditures). The percentage of federal funding is the federal medical assistance percentage (FMAP) that is determined for each state using a formula set forth in section 1905(b) of the Act, or other applicable federal matching rates specified by the statute.

The foundation of federal-state shared responsibility for the Medicaid program is that the state must participate in the financial burdens and risks of the program, which provides the state with an interest in operating and monitoring its Medicaid program in a manner that results in receiving the best value for the funds expended. Sections 1902(a), 1903(a), and 1905(b) of the Act require states to share in the cost of medical assistance and in the cost of administering the state plan. Section 1902(a)(2) of the Act and its implementing regulation in part 433, subpart B require states to share in the cost of medical assistance expenditures and permit other units of state or local government to contribute to the financing of the non-federal share of medical assistance expenditures. These provisions are intended to safeguard the federal-state partnership, irrespective of the Medicaid delivery system or authority (for example, FFS, managed care, and demonstration authorities), by ensuring that states are meaningfully engaged in identifying, assessing, mitigating, and sharing in the risks and responsibilities inherent in a program as complex and economically significant as Medicaid and are accordingly motivated to administer their programs economically and efficiently.

Of the permissible means for financing the non-federal share of Medicaid expenditures, the most common is through state general funds, typically derived from tax revenue appropriated directly to the Medicaid agency. Revenue derived from health care-related taxes can be used to finance the non-federal share only when consistent with federal statutory requirements at section 1903(w) of the Act and implementing regulations at part 433, subpart B. The non-federal share may also be funded in part from provider-related donations to the state, but these donations must be ''bona fide'' in accordance with section 1903(w) of the Act and implementing regulations, which means truly voluntary and not part of a hold harmless arrangement that effectively repays the donation to the provider (or to providers furnishing the same class of items and services).

Non-federal share financing sources can also come from IGTs or certified public expenditures (CPEs) from local units of government or other units of state government in which non-state governmental entities contribute funding of the non-federal share for Medicaid either by transferring their own funds to and for the unrestricted use of the Medicaid agency or by certifying to the state Medicaid agency the amount of allowed expenditures incurred. In each instance, allowable IGTs and CPEs, as with funds appropriated to the state Medicaid Agency, must be derived from state or local tax revenue or from funds appropriated to state university teaching hospitals. IGTs may not be derived from impermissible health care-related taxes or provider-related donations (discussed below); they are subject to all applicable federal statutory and regulatory restrictions. Even when using funds contributed by local governmental entities, the state must meet the requirements at section 1902(a)(2) of the Act and § 433.53 that obligate the state to fund at least 40 percent of the non-federal share of total Medicaid expenditures (both service related and administrative expenditures) with state funds. Additionally, these authorities require states to assure that a lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the state.

The extent to which private providers may participate in the funding of any Medicaid payment (for example, managed care, FFS base, or supplemental payments) is essentially restricted to the state's authority to levy limited health care-related taxes and to rely on bona fide provider-related donation in accordance with statutory and regulatory requirements. Since the use of IGTs and CPEs are restricted to governmental entities, states and providers increasingly have turned to the use of health care-related taxes to enable the maintenance of, or increases to, Medicaid payments to providers. In addition, several states have explored the use of provider-related donation arrangements to further leverage private provider funding.

b. Current CMS Review of Medicaid Financing and Oversight Concerns

We employ various oversight mechanisms to review state methods for funding the non-federal share of Medicaid payments including, but not limited to, reviews of proposed SPAs, quarterly financial reviews of state expenditures reported on the Form CMS–64, focused financial management reviews, and reviews of state health care-related tax and provider-related donation proposals and waiver requests. As discussed in detail above, states

must submit Medicaid SPAs to CMS for review and approval when adding or changing FFS provider payment methodologies. We review the SPAs to ensure the methodologies meet all federal requirements and the proposed payments and sources of the non-federal share may be approved and serve as the basis for FFP. In making approval decisions, we ask for certain information from states to document the source of the non-federal share during our SPA review process.

In response to our inquiries, states will typically describe whether the non-federal share is sourced through funds appropriated by the state legislature directly to the single state Medicaid agency, or whether the state relies on state or local government units to participate in funding the non-federal share through IGTs or CPEs. Additionally, states are asked to disclose whether the underlying financing involves a health care-related tax or a provider-related donation. When states rely on IGTs and CPEs as the source of the non-federal share, we request details on the transferring or certifying entities that participate in funding expenditures, including assurances that the entities are units of government, and the source of a unit of government's IGT. Based on the information that we receive from states, we may also ask for additional documentation to ensure the source of non-federal share complies with all applicable federal laws, regulations, and requirements, particularly those describing permissible health care-related taxes and provider-related donations.

Though our current SPA review processes allow us to ensure states identify a permissible source of non-federal share at the time that we approve an amendment, we have no reliable mechanism to track and understand whether the source of the non-federal share changes after a SPA has been approved. Based on studies conducted by the GAO (see for example, *States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection,* GAO–14–627, July 29, 2014), we are aware that states are increasingly reliant on non-state units of government to fund the non-federal share through IGTs, CPEs, and health care-related taxes. In fact, the GAO cites Medicaid supplemental payments and the associated non-federal share as a Medicaid High Risk Issue (*GAO Report to Congressional Committees High-Risk Series Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas,* GAO–19–157SP, March 6, 2019) and has called for CMS to implement improved oversight and data collection processes to track sources of non-federal share.

It is important to acknowledge that section 1903(w)(6)(A) of the Act specifically permits state and local units of government to share in financing the Medicaid program through IGTs and CPEs. Such local participation is inherent in the Medicaid program and recognizes the shared role that state and local government units can play in delivering Medicaid services. Nothing in this proposed rule would result in limiting state and local government units from contributing to the Medicaid program through allowable IGT and CPE funding sources. However, as discussed in the GAO's studies, the increasing reliance on Medicaid funding derived from units of state and local government may serve to undermine the state and federal financing partnership, as where states establish payment methodologies that favor certain providers solely on the basis of whether a unit of state or local government can provide the non-federal share to support Medicaid supplemental payments. Notably, section 1902(a)(2) of the Act requires states to assure that a lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan. We have concerns that, in certain circumstances, increased reliance on units of states or local government to fund the non-federal share may result in conflicts with section 1902(a)(30)(A) of the Act.

For example, we have identified and worked to address various Medicaid financing arrangements that appear designed to increase the federal share of Medicaid funding without a commensurate state or local contribution as required by sections 1902(a), 1903(a), and 1905(b) of the Act, which require states to share in the cost of medical assistance and in the cost of administering the state plan. We have identified manipulations of Medicaid UPL demonstration calculations that would serve to increase a state's ability to make supplemental payments above a reasonable Medicare estimate in states that have used, or proposed to use, an unallowable IGT to fund the state share of a Medicaid supplemental payment. We have also identified the manipulation of cost identification data providers rely on to certify Medicaid expenditures through a CPE process that, whether intentional or not, results in the federal government paying for costs that are unallowable under the Medicaid program.

Some of the more complicated, and unallowable, Medicaid financing arrangements we have reviewed resulted from public-private partnership arrangements between private entities and units of government. These arrangements attempt to mask non-bona fide provider-related donations as an allowable IGT and result in increased supplemental payments to the donating private entity or entities. Discussed in detail in State Medical Director Letter (SMDL) 14–004 and elsewhere in this preamble, partnership arrangements between a private provider and a government entity have involved the private provider providing cash, a service, or other in-kind donation to the government entity that is seemingly unrelated to the Medicaid program. In exchange for the private provider's contribution, the government entity will make an IGT to the Medicaid agency, which is then used as the non-federal share of supplemental Medicaid payments which are then returned to the private entity to repay them for the non-bona fide provider-related donation consistent with the underlying hold harmless agreement. The IGT is derived from funds that the government entity previously would have spent on the medical services (or other obligation) that are now being provided or paid for by the private entity. These funds would not be available to use as state share of Medicaid expenditures, if not for the public-private partnership arrangement, since the funds are derived from the non-bona fide provider-related donation (and not derived from state or local tax revenue or from funds appropriated to the state university teaching hospitals).[7]

The provisions of this proposed rule seek to address these and similar financing concerns through a number of strategies. Proposed improvements to state reporting associated with supplemental payments and sources of the non-federal share would allow CMS to monitor changes in non-federal share funding after a SPA is approved and any associated increases in federal expenditures for supplemental payments, relative to state expenditures. Additional specificity in definitions relevant to Medicaid financing arrangements and in requirements for information states must provide to support various funding mechanisms and supplemental payments would strengthen oversight of program expenditures by us and the states. Finally, we propose to address certain egregious funding schemes that mask

[7] Dep't of Health & Human Servs., CMS, State Medicaid Director Letter 14–004, Accountability #2: Financing and Donations, 3, (2014), *https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-004.pdf.*

non-bona fide donations as allowable IGTs by clarifying where an indirect hold harmless arrangement may exist and by expressly prohibiting supplemental payments that support these schemes. Together, proposed new policies and the proposed codification of existing policies related to Medicaid financing aim to provide CMS and states with better information and guidance to identify existing and emerging financing issues, provide more clarity on allowable financing arrangements, promote state accountability, and strengthen the fiscal integrity of the Medicaid program.

4. Health Care-Related Taxes and Provider-Related Donations

a. Background

States first began to use health care-related taxes and provider-related donations in the mid-1980s as a way to finance the non-federal share of Medicaid payments (Congressional Research Service, ''Medicaid Provider Taxes'', August 5, 2016, p.2). Providers would agree to make a donation or would support (or not oppose) a tax upon their activities or revenues, and these mechanisms would generate funds that could then be used to raise Medicaid payment rates to the providers. Frequently, these programs were designed to hold Medicaid providers ''harmless'' for the cost of their donation or tax payment. As a result, federal expenditures rapidly increased without any corresponding increase in state expenditures, since the funds used to increase provider payments came from the providers themselves and were matched with federal funds. In 1991, the Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (Pub. L. 102–234, enacted December 12, 1991) to curb the use of provider-related donations and health care-related taxes to finance the non-federal share of Medicaid expenditures. Section 1903(w)(1)(A) of the Act specifies that, for purposes of determining the federal matching funds to be paid to a state, the total amount of the state's Medicaid expenditures must be reduced by the amount of revenue the state collects from impermissible health care-related taxes and non-bona fide provider-related donations.

The statute requires that taxes be imposed on a permissible class of health care items or services; and be broad based, meaning that all non-federal, nonpublic providers and all items and services within a class of health care items or services would be taxed, as well as uniform, meaning that the tax rate would be the same for all health care items or services in a class, as well as providers of such items or services. The statute prohibits hold harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers. The Secretary is required by section 1903(w)(3)(E) of the Act to waive either the broad based and/or uniformity requirements as long as the state establishes, to the Secretary's satisfaction, that the net impact of the tax and associated expenditures is generally redistributive in nature, and the amount of the tax is not directly correlated to Medicaid payments for items and services with respect to which the tax is imposed.

Section 1903(w)(2)(A) of the Act defines a provider-related donation as any donation or other voluntary payment (in-cash or in-kind) made directly or indirectly to a state or unit of a local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the state plan for which payment is made under section 1903(a)(2), (3), (4), (6), or (7) of the Act (generally, administrative goods and services). Section 1903(w)(2)(B) of the Act defines a bona fide provider-related donation as a provider-related donations that has no direct or indirect relationship (as determined by the Secretary) to payments made under title XIX to that provider, to providers furnishing the same class of items and services as the donating provider, or to any related entity, as established to the satisfaction of the Secretary. The statute gives the Secretary the authority to specify, by regulation, types of provider-related donations that will be considered to be ''bona fide.'' Regulations at part 433, subpart B describe the requirements necessary, irrespective of the Medicaid delivery system authority (for example, FFS, managed care, or demonstration authorities), for a donation to be considered bona fide.

In response to the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, we published the ''Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals'' interim final rule with comment period in the November 24, 1992 **Federal Register** (57 FR 55118) (November 1992 interim final rule) and the subsequent final rule published in the August 13, 1993 **Federal Register** (58 FR 43156) (August 1993 final rule) establishing when states may receive funds from provider-related donations and health care-related taxes without a reduction in medical assistance expenditures for the purposes of calculating FFP. These rules established the statistical tests used to judge requests for waivers of the broad-based and uniformity requirements and defined bona fide provider-related donations.

After the publication of the August 1993 final rule, we revisited the issue of health care-related taxes and provider-related donations in the ''Medicaid Program; Health-Care Related Taxes'' final rule (73 FR 9685) which published in the February 22, 2008 **Federal Register** (February 2008 final rule). The February 2008 final rule, in part, implemented section 1903(w)(7)(A)(viii) of the Act by expanding the Medicaid managed care organization (MCO) class of health care items and services (73 FR 9698) to include all MCOs specified in section 6051 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171, enacted February 8, 2006). Specifically, it amended the class of health care services and providers specified in § 433.56(a)(8) from services of Medicaid MCOs to services of MCOs including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). As a result of this change, states could no longer impose a tax solely on MCOs providing services to only Medicaid beneficiaries.

The regulation also made explicit that certain practices would constitute a hold harmless arrangement, in response to certain state tax programs that we believed contained hold harmless provisions. Five states had imposed a tax on nursing homes and simultaneously created programs that awarded grants or tax credits to private pay residents of nursing facilities that enabled these residents to pay increased charges imposed by the facilities, which thereby recouped their own tax costs. We believed that these payments held the taxpayers (the nursing facilities) harmless for the cost of the tax, as the tax program compensated the facilities indirectly, through the intermediary of the nursing facility residents. However, in 2005, the DAB (Decision No. 1981) ruled that such an arrangement did not constitute a hold harmless arrangement under the regulations then in place. To clarify agency interpretation that this practice does constitute a hold harmless arrangement, the February 2008 final rule clarified the direct guarantee test found at § 433.68(f) by specifying that a direct guarantee to hold the taxpayer harmless for the cost of the tax through a direct or indirect payment will be found when, ''a payment is made available to a taxpayer or party related

to a taxpayer'' so that a reasonable expectation exists that the taxpayer will be held harmless for all or part of the cost of the tax as a result of the payment (73 FR 9694). As an example of a party related to the taxpayer, the preamble cited the example of, ''as a nursing home resident is related to a nursing home (73 FR 9694). As a result, whenever there existed a ''reasonable expectation'' (73 FR 9695) that the taxpayer would be held harmless for the cost of the tax, a hold harmless situation would exist and the tax would be impermissible.

b. Concerns Relating to Health Care-Related Tax Waivers

States and their units of local government have the ability to impose broad-based and uniform health care-related taxes without explicit CMS approval. However, if the tax implemented by the state or unit of local government is not broad-based and/or uniform, the state must apply to CMS for a waiver of the applicable tax requirements. As part of these requirements, the state must demonstrate to the satisfaction of the Secretary that the tax passes a statistical test specified in regulation to waive either the broad-based requirement, or the uniformity requirement, or both, as specified in § 433.68(e)(1) or (2). These tests were designed to evaluate whether or not a proposed tax would be ''generally redistributive,'' as required by section 1903(w)(3)(E)(ii)(I) of the Act. The preamble to the November 1992 interim final rule indicated that, in interpreting the statutory phrase ''generally redistributive,'' we ''attempted to balance our desire to give states some degree of flexibility in designing tax programs with our need to preclude use of revenues derived from taxes imposed primarily on Medicaid providers and activities'' (57 FR 55128). In the preamble of August 1993 final rule, we interpreted ''generally redistributive'' to mean ''the tendency of a state's tax and payment program to derive revenues from taxes imposed on non-Medicaid services in a class and to use these revenues as the state's share of Medicaid payments'' (57 FR 55128).

At the time of these rules, we anticipated the two mathematical tests in § 433.68(e)(1) and (2) would be sufficient to ensure that a proposed tax would be ''generally redistributive,'' as we interpret that statutory language. Specifically, the first test known as the ''P1/P2 test'' in § 433.68(e)(1) is required for taxes that are uniform, but not broad based. At the time of these rules, we anticipated the two mathematical tests in § 433.68(e)(1) and (2) would be sufficient to ensure that a proposed tax would be ''generally redistributive,'' as we interpret that statutory language. Specifically, the first test known as the ''P1/P2 test'' in § 433.68(e)(1) is required for taxes that are uniform, but not broad based. As described in the November 1992 interim final rule (57 FR 55128), the test requires the State to calculate the proportion of the tax applicable to Medicaid under a broad-based tax (designated as P1), and the proportion applicable to Medicaid under the tax as imposed by the State (called P2). By dividing P1 by P2, the test was intended to measure whether or not the uniform, but non-broad based tax was redistributive. Resulting values higher than one indicated the tax was more redistributive than a broad-based and uniform tax, while values less than one would indicate it was less redistributive and placed a disproportionate share of the tax burden on the Medicaid program (57 FR 55128).

The November 1992 interim final rule (57 FR 55128) also described the second test known as the ''B1/B2 test,'' applying in situations when the state requests a waiver of the uniformity requirement whether or not the tax is broad-based. In this test, the State would calculate the slope of two linear regressions: One for the tax program for which waiver is requested, and one for the tax if it were applied uniformly and as a broad-based tax where the slope (that is, the X coefficient) of the linear regression applicable to the hypothetical broad-based uniform tax (called B1) is divided by the slope of the linear regression applicable to the tax for which a waiver is sought (called B2) (57 FR 55128). Similar to the P1/P2 test for uniform taxes that are not broad based, the B1/B2 test was designed to show that values higher than one indicate the non-uniform tax was more redistributive than a broad-based and uniform tax, while values less than one would indicate that it was less redistributive and disproportionately burdened the Medicaid program (57 FR 55128).

However, subsequent experience has proven that the two mathematical tests do not ensure, in all cases, that proposed taxes that pass the applicable test are generally redistributive. Certain states have identified a loophole where taxes can pass the statistical test(s) despite their imposition of undue burden on the Medicaid program. For example, several states have imposed taxes on managed care entities that, by design, clearly impose a greater and undue tax burden on the Medicaid program than other payers. States have structured the taxes by dividing the universe of entities subject to taxation into smaller taxpayer groups based on various attributes, such as annual member-months by payer. In this example, states have imposed significantly higher rates on some taxpayer groups defined by a relatively higher number of Medicaid member-months than on commercial payer member-months, with some Medicaid activity (member-months in this example) subject to taxation at a rate more than 25 times higher than the rate for otherwise similar commercial activity. Counterintuitively, these taxes are able to pass the statistical tests designed to ensure that the tax is generally redistributive, despite the states' own information indicating, in one state, that plan revenue from Medicaid paid 88 percent of the assessed tax even though only 45 percent of the member months subject to the tax were attributable to Medicaid beneficiaries. Under these tax conditions, the proposed rule would give CMS the authority to determine that the tax is not generally redistributive, despite the fact that it could pass the applicable statistical test under current regulations, because it places an undue burden on the Medicaid program (as indicated in the example by the disproportionate share of the tax attributable to Medicaid relative to Medicaid's share of total member months). The August 1993 final rule noted that, ''to the extent a tax is imposed more heavily on low Medicaid utilization than high Medicaid providers, the tax would be considered redistributive,'' in that case, there would be a ''tendency of a state's tax and payment program to derive revenues from taxes imposed on non-Medicaid services in a class and to use these revenues as the state's share of Medicaid payments'' (57 FR 55128). However, in the situations involving the type of statistical manipulation described above, the exact opposite is the case. In these instances, states are imposing taxes that place a greater tax burden on Medicaid-reimbursed health care items and services, and providers of such items and services, than on comparable entities not reimbursed by Medicaid. Such a tax is not generally redistributive in nature.

In an effort to more effectively prohibit tax arrangements that are not generally redistributive, for us to approve a waiver of the broad based and/or uniformity requirements, this proposed rule would require that a tax must not impose undue burden on health care items or services paid for by Medicaid or on providers of such items and services that are reimbursed by

Medicaid. Generally, as discussed in greater detail below, we would provide that the tax may not be structured in a way that places a greater tax burden on taxpayer groups that have a greater level of Medicaid activity, as proposed to be defined below, than those that have less or no Medicaid activity.

Some states have designed non-broad based and/or non-uniform tax structures that exclude, or lower tax rates on, taxpayers grouped together on the basis of their lack of or low levels of Medicaid activity compared to other taxpayers in the class. We believe that such tax structures inherently impose undue burden on the Medicaid program, and therefore, do not meet the statutory generally redistributive requirement. Similarly, we are concerned that some states might provide tax relief to taxpayers grouped together ostensibly on a basis other than Medicaid activity, but that the specific basis for the grouping is designed to obscure a true purpose to define the group based on lack of or relatively low Medicaid activity. For example, a state could attempt to exclude from taxation or place a lower tax rate on all hospitals within a certain geographic area that has certain demographic characteristics, such as all counties with populations between 40,000 and 85,000 residents. Under the particular conditions in the state, it could result that this commonality serves as a substitute for the included hospitals having low or no Medicaid activity. In this example, the commonality could be viewed as a substitute for Medicaid activity if only two counties in the state met this criteria, and the hospitals in these two counties had relatively low Medicaid activity compared to hospitals in the other counties in the state, as might occur in the case of a county with relatively low Medicaid enrollment in the county and surrounding counties. Such a tax program likely would result in the Medicaid program funding a disproportionate share of tax revenues, as counties containing hospitals with low levels of Medicaid activity would be excluded by the structure of the tax. In that case, the burden of the tax would fall upon hospitals with higher Medicaid activity. Therefore, as discussed below, we are proposing to consider tax structures not to be generally redistributive when taxpayers are grouped together in a manner that isolates taxpayers with relatively higher or lower levels of Medicaid activity and when taxpayers with relatively higher Medicaid activity are taxed relatively more heavily. We propose to consider the totality of the circumstances when deciding whether the tax program involves taxpayer groupings that, by proxy, have the effect of sorting taxpayers by relatively higher or lower levels of Medicaid activity. The proposed rule would retain the two statistical tests currently at § 433.68 when determining whether or not the proposed tax waiver would be generally redistributive as required by statute. However, in determining whether or not a tax program is generally redistributive, consideration would also be given to examine the totality of the circumstances in addition to the applicable statistical test.

We aim to balance preserving state flexibility in designing tax programs with ensuring health care-related taxes meet statutory generally redistributive requirements. We do not intend to interfere with states' ability to exclude from taxation or impose lower tax rates on health care items and services or on providers based on genuine commonalities that meet legitimate policy objectives. However, it is incumbent upon us to prevent tax structures designed to impose an undue burden on the Medicaid program, including on participating providers and/or health care items and services for which Medicaid pays, in contravention of federal statutory requirements.

c. Concerns Relating to the Definition of a Health Care-Related Tax

Section 1903(w)(3)(A)(i) of the Act defines a health care-related tax using multiple tests that must be applied to tax proposals. Section 1903(w)(3)(A)(i) of the Act stipulates health care-related taxes are related to: (1) Health care items or services; (2) the provision of, or the authority to provide, health care items or services; or (3) payment for health care items or services. Section 1903(w)(3)(A)(ii) of the Act further stipulates that a tax is a health care-related tax when it is not limited to health care-related items or services, but provides for treatment of individuals or entities that provide or pay for health care-related items or services that is different than treatment of ''other individuals or entities.'' Any tax must be fully evaluated against all components of the statutory definition to determine whether it qualifies as a health care-related tax.

In determining whether a tax is related to health care items or services, section 1903(w)(3)(A) of the Act also specifies that if at least 85 percent of the tax burden falls on health care providers, it is considered to be related to health care items or services. However, this provision does not establish a safe harbor for any tax on health care providers that falls below the threshold. Section 433.55(c) specifies that if less than 85 percent of the tax burden falls on health care items or services, the tax may still be considered to be health care-related if differential treatment exists for entities providing or paying for health care items or services relative to other entities. If less than 85 percent of the tax burden falls on health care items or services, the treatment of those entities must still be analyzed to determine if the tax treats them equally.

Outside oversight bodies have raised concerns that states have attempted to subvert federal regulations regarding health care-related taxes by masking them as part of larger non-health care-related taxes. States may do so by including impermissible health care-related taxes inside larger tax programs that include non-health care-related taxes in such a way so as to avoid being considered a health care-related tax in accordance with § 433.55. The OIG identified one such attempt in a May 2014 report (A–03–13–00201),[8] in which the OIG described a state that appeared to be taxing only income from Medicaid MCO services by incorporating only Medicaid MCOs into larger (often existing) state and local taxes otherwise unrelated to Medicaid, despite the DRA provisions which prohibited taxation of only Medicaid MCOs. Specifically, section 6051 of the DRA amended section 1903(w)(7)(A) of the Act to change the relevant permissible class of health care items and services from ''[M]edicaid managed care organizations'' to MCOs generally. In its report, the OIG recommended that CMS issue clarification to states regarding its interpretation of statute and regulations regarding health care-related taxes as soon as possible and warned that failure to do so could result in a proliferation of similar Medicaid MCO taxes if states believed that it was permissible to incorporate otherwise impermissible health care-related taxes into pre-existing, non-health care-related tax programs as long as less than 85 percent of the tax burden fell on health care providers. Absent clarifying guidance, we were also concerned that states could mistakenly believe that selectively incorporating a tax on health care items or services for which Medicaid is a significant payer, like home and community-based services (HCBS), into a broader state tax program would result in the HCBS tax not being defined as health-care related.

[8] *https://oig.hhs.gov/oas/reports/region3/31300201.pdf.*

In July 2014, we issued State Health Official (SHO) letter #14–001 (SHO #14–001) on health care-related taxes. This guidance clarified that even in cases where less than 85 percent of a tax falls on health care items or services, the tax can be considered health care-related. If a tax treats health care items or services differently, the tax is still considered a health care-related tax. Specifically, SHO #14–001 stated that taxing a subset of health care services or providers at the same rate as a statewide sales tax, for example, does not result in equal treatment if the tax is applied specifically to a subset of health care services or providers (such as only Medicaid MCOs), since the providers or users of those health care services are being treated differently than others who are not within the specified universe. Despite this guidance, some states have continued to selectively incorporate health care items or services into larger tax programs that also levy taxes on goods and services unrelated to health care in an apparent attempt to circumvent the statutory restrictions on health care-related taxes. These impermissible tax arrangements have not been limited to states incorporating only Medicaid MCOs into broader state or local taxes, but have included other health care items or services, such as private non-medical institution services.

Often, the health care items and services (or providers) subject to such taxes are subsets of health care items and services (or providers) highly utilized by Medicaid beneficiaries and/or do not meet the permissible class definition in § 433.56. For example, a state may try to impose a tax on a service that is mostly (if not entirely) reimbursed by Medicaid, which does not fall under an existing permissible class at § 433.56, such as HCBS. A state may include a service like this among other goods and services that are taxed under a larger tax program that is not explicitly related to health care, such as a tax program principally concerned with natural resources or telecommunications. The proposed rule clarifies that by targeting a specific type of health care-related item or service and incorporating it into a larger tax (the HCBS portion of this tax to continue with the above example) would be considered health care-related—even if 85 percent of the revenue from the tax overall did not come from health care-related items or services or providers of such items or services.

The preamble to the November 1992 interim final rule with comment period discussed the circumstances in which health care items and services included within a larger non-health care related-tax would cause the tax to be considered health care-related in situations where they did not constitute 85 percent of the tax revenue. To illustrate when such taxes would or would not be considered health care-related, the preamble gave the hypothetical example of a 5 percent tax on the gross revenues of hospitals and gas stations that generated $100 million dollars in tax revenue. The preamble stated that if the hospitals paid $90 million of the tax, then the tax would be considered to be health care-related because this would exceed the 85 percent threshold. However, if the hospitals paid only $60 million dollars, then the tax would not be considered health care-related because the tax rate is the same for health care items or services and non-health care items or services and the hospitals would be taxed at under the 85 percent threshold established in regulation.

We are aware that this example may not have been as clear as possible and could have led to confusion as to what different treatment for health care items and services means in the context of § 433.55(c). Specifically, we are concerned some parties misinterpreted this example as indicating approval of states selecting specific health care-related items and services for inclusion within a broader tax program without the tax being considered health care-related as long as less than 85 percent of the tax burden falls on such items and services. We believe this potential misinterpretation is inconsistent with section 1903(w)(3)(A)(ii) of the Act, § 433.55(c), and the preamble to the August 1993 final rule, which stated in response to a commenter, ''We believe section 1903(w)(3)(A)(ii) [of the Act] prevents the state from implementing a tax that may be masked by an existing non-health care-related tax'' (58 FR 43160). In the aforementioned preamble example, a tax in which hospitals paid $60 million and gas stations paid $40 million under a flat 5 percent gross revenues tax was not necessarily considered health care-related because the burden on providers of health care items and services is less than 85 percent. While § 433.55(c) states that in situations where less than 85 percent of the tax burden falls on health care items or services the tax may still be considered health care-related if differential treatment exists for entities providing or paying for health care items or services. However, § 433.55(c) does not specify the reference group against which one should measure differential treatment.

While statute and regulation specify that differential treatment results in a tax being considered health care-related, existing law and regulations do not explicitly describe what constitutes differential treatment. Therefore, we are proposing to clarify what constitutes differential treatment to clarify when taxes are health care-related and when they are not. We believe this clarification would assist in prohibiting state or local units of government from incorporating an impermissible tax on health care items or services into a larger existing tax, such as a state-wide sales tax, or creating a new tax that treats health care items or services differently to avoid federal statutory and regulatory requirements related to health care-related taxes. Therefore, we are proposing to clarify that differential treatment occurs when a tax program treats some individuals or entities that are providing or paying for health care items or services differently than (1) individuals or entities that are providers or payers of any health care items or services that are not subject to the tax or (2) other individuals or entities that are subject to the tax.

Due to the complexity of this issue, we are providing a few illustrative examples of when a tax program does or does not constitute differential treatment. First, we are providing examples relating to evaluating differential treatment of individuals or entities that are providing or paying for health care items or services that are subject to the tax compared to individuals or entities that are providers or payers of any health care items or services that are not subject to the tax. For example, if the state imposes a tax on telecommunication services, but also includes inpatient hospital services, this would constitute differential treatment. Given that inpatient hospital services are not reasonably related to the other services subject to taxation (that is, telecommunication services), as discussed below, we would consider the tax to be treating inpatient hospital services differently than other individuals or entities providing or paying for health care items or services, which are not included in the tax. While some might consider this example as being similar to the example involving a tax on gas stations and hospitals in the November 1992 interim final rule, we are taking this opportunity to clarify our interpretation of section 1903(w)(3)(A)(ii) of the Act. We have never ruled out the extistence of differential treatment in all instances where health care items or services are included in a larger non-health care-related tax program, even where less than 85 percent of the tax burden falls on health care providers and all entities

and services are subject to the same tax rate. As we emphasized in the 2014 SHO letter, taxes where less than 85 percent of the tax burden falls on health care items or services may still be considerd health care-related if only a subset of health care items or services are taxed, even if they are taxed at the same rate as items or services not related to health care that are also included in the tax. Prior to the issuance of the 2014 SHO letter, several states attempted to mask taxes on such subsets, including Medicaid-only MCOs, by including them within larger, non-exclusively health care-related tax programs. Notably, the taxes on Medicaid-only MCOs would not have been approvable on their own, if implemented by the state separately from the taxation of items and services unrelated to health care. States included taxes on Medicaid-only MCOs within larger, non-exclusively health care-related tax programs, such as sales taxes and gross receipts taxes, in an attempt to bypass federal statutory and regulatory prohibitions by effectively masking the health care-related component of the tax. We have worked with the OIG to ensure that these and similar practices that ran counter to the letter and spirit of federal statute and regulation were stopped. We view this proposed rule as a continuation of our efforts to ensure that health care-related taxes follow all applicable requirements.

In instances where a state or other unit of government imposes a tax on reasonably related items or services that includes some non-health care items or services and some health care items or services, we would not consider differential treatment to occur if all health care items or services that are reasonably related to the taxed universe are included in the tax and all health care items and services subject to the tax are taxed at the same rate as the non-health care items or services subject to the tax. We will consider items or services within the tax to be reasonably related if there exists a logical or thematic connection between the items or services or individuals or entities being taxed. Examples of such a connection could include, but would not be not limited to, industry, such as electronics; geographical area, such as city or county; net revenue volume; or number of employees. When determining whether or not individuals, entities, items, or services are reasonably related, we will examine the parameters of the given tax. In this context, the parameters of the tax means the grouping of individuals, entities, items or services, on which the tax is imposed. For example, if a state or unit of government imposed a one percent tax on all revenue from licensed professional services (for example, accounting services, legal services, etc.), including revenue from services provided by medical professionals, this would not constitute differential treatment, because all health care items or services reasonably related to the universe of items and services subject to the tax are themselves subject to the tax, and such services are taxed at the same rate as the included non-health care items or services. Provided that less than 85 percent of the tax burden falls on health care providers, the tax in this example would not be considered a health care-related tax. However, if the state or unit of government imposing the tax structures the parameters of the tax in such a way to include items or services that are not reasonably related and only selected health care items or services are included in the tax while others are excluded, the tax would be considered health care-related, as in the above example of a tax on telecommunications services and inpatient hospital services.

When determining whether or not differential treatment occurs, we evaluate the totality of the circumstances of the arrangement. For example, under some circumstances, it could be permissible for the state or unit of government to impose a tax on businesses employing 50 to 500 full-time equivalent (FTE) employees; such that the tax likely would include a number of entities providing or paying for health care items and services, and a number of entities selling non-health care items and services, within its parameters. However, it could be that, within a certain geographical area of the state, most businesses employing 50 to 500 FTE employees are entities providing or paying for health care items and services. If the tax were geographically targeted to include this area but not other areas of the state or unit of government's jurisdiction with a more diverse mix of businesses employing 50 to 500 FTE employees, this targeting could be evidence that the state or unit of government is using the numeric FTE employee parameter as a proxy to concentrate the tax burden on certain entities providing or paying for health care items or services.

While the examples given above illustrate hypothetical taxes we would consider to be health care-related where less than 85 percent of the tax falls on providers of health care items or services, they do not represent an exhaustive list of all possible forms of differential treatment as we cannot foresee every possible arrangement. Differential treatment may still exist even in situations other than those described previously and identified in proposed § 433.55(c)(1) and (2). Therefore, we are also proposing to examine the parameters of the tax as defined by the state or other unit of government, as well as the totality of the circumstances relevant to which individuals, entities, items, or services are subject (and not subject) to the tax, and the tax rate applicable to each, in determining whether the tax program involves differential treatment as provided in section 1903(w)(3)(A)(ii) of the Act. The proposed rule aims to preserve appropriate state flexibility on tax and health care policy, while clarifying what constitutes differential treatment within the meaning of section 1903(w)(3)(A)(ii) of the Act and § 433.55(c) and helping ensure that states do not design tax structures to circumvent statutory requirements.

d. Concerns About Hold Harmless and Health Care-Related Taxes

We have become aware of impermissible arrangements that exist where a state or other unit of government imposes a health-care related tax, then uses the tax revenue to fund the non-federal share of Medicaid payments back to the taxpayers. The taxpayers enter into an agreement, which may or may not be written, to redistribute these Medicaid payments to ensure that taxpayers, when accounting for both the original Medicaid payment (from the state, unit of local government, or MCO) and any redistribution payment from another taxpayer or taxpayers, receive all or any portion of their tax amount back. The net effect of the arrangement is clear evidence that taxpayers have a reasonable expectation that their forthcoming Medicaid payment (including any redistribution), which results in participating taxpayers being held harmless for all or a portion of the tax amount. Regardless of whether the taxpayers participate voluntarily, whether the taxpayers receive the Medicaid payments from a MCO, or whether taxpayers themselves make redistribution payments from funds other than Medicaid to other taxpayers, the net effect of the arrangement is the same: The taxpayers have a reasonable expectation to be held harmless for all or a portion of their tax amount.

Such arrangements undermine the fiscal integrity of the Medicaid program and are inconsistent with existing statutory and regulatory requirements prohibiting hold harmless arrangements. The February 2008 final rule on health

care-related taxes and provider-related donations specified that hold harmless arrangements prohibited by § 433.68(f)(3) exist ''. . . when a state payment is made available to a taxpayer or a party related to the taxpayer (for example, as a nursing home resident is related to a nursing home), in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax'' (73 FR 9694). Despite the statutory and regulatory prohibitions, we are concerned that states, local units of government, and/or providers continue to design and execute hold harmless practices that are antithetical to federal law and regulation. To aid in preventing and ending such complex financing arrangements, the proposed rule would add clarifying language to the hold harmless definition in § 433.68(f)(3) to specify that CMS considers a ''net effect'' standard in determining whether or not a hold harmless arrangement exists.

In the example cited above involving some taxpayers that received more in Medicaid reimbursement (from the state, unit of local government, or MCO) than the amount of tax paid which they then transfered to other taxpayers that did not, we would consider such an arrangement to include a hold harmless arrangement because the taxpayers had a reasonable expectation to be held harmless from all or a portion of the cost of their tax through either or both of the Medicaid payments from the state or other unit of government or from MCOs, and redistribution payments from other taxpayers participating in the arrangement whose payments from the state or other unit of government or from MCOs met or exceeded their own tax cost. The fact that a private entity makes the redistribution payment does not change the essential nature of the payment, which constitutes an indirect payment from the state or unit of government to the entity being taxed that holds it harmless for the cost of the tax. As noted in the February 2008 final rule, ''An indirect payment to the taxpayer would also constitute a direct guarantee'' (73 FR 9896). When looking for the presence or absence of a hold harmless arrangement in health care-related taxes, conclusive evidence lies not in the presence or absence of individual elements, but the sum total of all the elements when viewed collectively. While the presence or absence of a single individual factor may not be sufficient to establish conclusively that such an arrangement exists, the cumulative effect of many such factors may be sufficient to make such a determination. Only after reviewing the totality of the circumstances and making a judgment about how the overall arrangement operates are we able to determine whether or not the state provides for a direct or indirect payment, offset, or waiver that holds the taxpayer harmless for any portion of the tax. This proposal does not reflect any change in policy or approach, but merely codifies currently prohibited practices, and would provide further clarification to states regarding how they may finance the non-federal share of Medicaid expenditures.

e. Concerns Regarding Permissible Tax Classes of Health Care Services and Providers

Over the past several years, we have become aware that several states have instituted taxes on health insurers or health insurance premiums. In an effort to maintain consistent federal oversight of health care-related taxes, modernize the permissible class definitions, and permit states additional flexibility to implement health care-related taxes, this rule proposes to add services of health insurers, other than MCOs listed in § 433.56 (a)(8), as permissible classes of health care items or services under § 433.56, under section 1903(w)(7)(A)(ix) of the Act. In an effort to avoid being overly prescriptive, we have decided against proposing a narrow definition of the term ''health insurer.'' However, the definition of ''health insurance issuer'' at 45 CFR 144.103 provides a helpful point of reference. That regulation defines a health insurance issuer as an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). However, the term health insurer in the proposed additional class at § 433.56, explicitly excludes MCOs such as HMOs because these organizations are already included under section 1903(w)(7)(A)(viii) of the Act, unlike the term health insurance issuer at § 144.103. The proposed class would include insurers that issue policies for the group market and/or the individual market, including such coverage with high-deductible or ''catastrophic'' plans. The proposed class would also include issuers of short-term limited-duration policies as defined in § 144.103, as well as issuers of coverage for ''excepted benefits'' defined in 45 CFR 146.145 in the group market and the individual market at 45 CFR 148.220, such as dental-only and vision-only policies. Such a health care-related tax could include, but need not be limited to, an assessment on health insurance premiums, covered lives, or revenue. The class may include cost sharing measures, including premiums, from Medicare, such as private FFS plans under Medicare Advantage offered as part of Medicare Part C or prescription drug insurance plans as part of Medicare Part D, as well as any premiums paid by individuals as part of a section 1115 waiver where Medicaid funding is used for premium assistance to help beneficiaries purchase commercial health insurance plans. Such a tax cannot include CMS or any state agencies involved in administering title XVIII, title XIX, or title XXI, including state Medicaid agencies. We are soliciting comments on the definition of this permissible class to ensure that the appropriate entities and services are included.

f. Concerns Regarding Non-Bona Fide Provider-Related Donations

We are concerned that certain states, localities, and private health care providers have designed complex financing structures to mask non-bona fide, provider-related donations used to fund the non-federal share of Medicaid payments. States, localities, and private providers appear to be utilizing these complex arrangements to obfuscate the source of non-federal share and avoid the statutorily-required reduction to state medical assistance expenditures. They also appear to violate a variety of requirements in section 1903(w) of the Act and its implementing regulations, which mandate that the state's Medicaid expenditures for which FFP is provided shall be reduced by the sum of any revenues resulting from provider-related donations received by the state during the fiscal year other than bona fide provider-related donations. Such practices may also run afoul of section 1902(a)(30)(A) of the Act, which requires that payments be made consistent with efficiency, economy and quality of care. Additionally, they may result in payments that are inconsistent with the proper and efficient operation of the state plan (see section 1902(a)(4) of the Act) and its design for a cooperative state-federal partnership by generating increases in federal spending without a corresponding increase in state financial participation, with no direct link to additional services furnished, beneficiaries assisted, or other benefit to the Medicaid program.

Often, these arrangements involve a transfer of value of some kind from a private provider to a governmental entity and the governmental entity does

not reimburse the private entity at fair market value. For example, the transfer may involve the private provider assuming an obligation previously performed by a governmental entity without being reimbursed fair market value, performing services previously performed by a governmental entity without being reimbursed at fair market value, or renting real property from a governmental entity at a price above fair market value. In such cases, the difference between the fair market value of the assumption of the obligation, performance of the services, or rental value of the property and the value actually transferred is in effect a donation by the private provider to the governmental entity. The governmental entity then executes an IGT, funded by the donation, to the state Medicaid agency, which is then used to fund the non-federal share of Medicaid expenditures. The Medicaid agency then makes a supplemental payment to the private donating provider, which effectively compensates it for the value it transferred to the governmental entity (the assumption of an obligation, performance of services, or excess rent paid). Often, this arrangement will not be executed as a contract or other formal business arrangement, or otherwise reduced to writing of which evidence is available to us. Instead, it will be based on a series of reciprocal actions performed by each party. As a result of such an arrangement, the private provider makes a direct or indirect donation, and the state returns all or a portion of the value of the donation to the private provider effectively using only federal dollars without a corresponding outlay in state expenditures, and such an arrangement constitutes a non-bona fide donation becase there is a pre-existing hold harmless agreement. The net effect of such an arrangement is to artificially inflate the state Medicaid expenditures eligible for FFP, sometimes up to 100 percent, in a manner inconsistent with statute and regulation.

Recently, we have identified and taken action to prevent or end impermissible financing practices in which states have attempted to mask non-bona fide provider-related donations. Some of these arrangements include instances where transfers of licenses occur without consideration of, or below, fair market value from a private provider to a unit of government to enable formerly private providers to receive certain supplemental payments available to governmental providers. In other situations, governmental entities have leased the same facilities back to private providers at rents above fair market value as a way of allowing the private facilities to make non-bona fide donations to the governmental entity, which then transfers the funds to the state Medicaid agency through IGTs. Ultimately, these schemes have the net effect of reducing the overall percentage of total computable Medicaid expenditures funded with state dollars, while at the same time causing a corresponding increase in federal funding.

We have taken several steps to curtail public-private partnerships that lead to non-bona fide provider-related donations. In 2014, we issued SMDL #14–004, the second in a series of two SMDLs that discuss mutual obligations and accountability with respect to the Medicaid program for the federal government and states. SMDL #14–004 addressed the deleterious impact that public-private partnerships designed to skirt federal requirements concerning provider-related donations can have on fiscal integrity. In 2016, we issued a disallowance to recover FFP associated with impermissible provider-related donations where private providers assumed financial obligations of local governmental entities to free up government funds, and the freed up funds were then used as the state's share of supplemental payments to the donating provider. The CMS disallowance was upheld when the state appealed to the DAB (DAB No. 2886, Texas Health and Human Services Commission (2018)).

This proposed rule would clarify the hold-harmless definition related to donations to account for the net effect of complex donation arrangements, including where the donation takes the form of the assumption of governmental responsibilities. In the provisions of § 433.54 addressing when a guarantee would exist to hold the provider harmless for value related to a donation to the governmental entity, this proposed rule would establish a net effect standard. Any exchange of value that constitutes a governmental entity reimbursing a private entity for value related to the private entity's donation need not arise to the level of a legally enforceable obligation, but must be considered in terms of its net effect, thus incorporating the language in DAB No. 2886, Texas Health and Human Services Commission (2018). In that case, the DAB held that ''the net effect of the arrangements under review amounted to impermissible provider donations'' and that as a result, the supplemental payments made by state Medicaid agency to the private provider were impermissible (77 FR 25). The DAB also found that it is not necessary for a legally enforceable obligation to exist, such as under a statute or contract, for a donation to be found. In line with the Board's reasoning, we are proposing to establish a net effect standard to look at the overall arrangement in terms of the totality of the circumstances to judge if a non-bona fide donation of cash, services or other transfer of value to a unit of government has occurred. In § 433.52, the proposed definition of ''provider-related donation'' would clarify that the assumption by a private entity of an obligation formerly performed by a unit of government where the unit of government fails to compensate the private entity at fair market value would be considered an indirect donation made from the private entity to the unit of government. This proposed rule would also clarify that such an exchange need not arise to the level of a legally enforceable obligation.

C. Previous CMS Efforts To Understand and Monitor Medicaid Payments and Financing

We have already taken action to strengthen our approach to authorizing, monitoring, and evaluating Medicaid payments and financing to ensure that statutory and regulatory requirements are satisfied. To monitor supplemental payments made under state plan authority, in 2010, we began requiring states to separately report through MBES amounts paid for the most common and largest supplemental payments in accordance with § 430.30(c). States report statewide aggregate amounts for only some supplemental payments and do not include provider-level detail. In 2013, we issued SMDL #13–003, which discussed a submission process to comply with the UPL requirements in §§ 447.272 and 447.321. This SMDL discussed methods of complying with these two regulations through annual UPL submissions apart from the normal state plan process, as the regulations do not specify time frames for the submission of UPL demonstrations. The SMDL also provided further guidance regarding UPL calculation methodologies and requested that states identify the source of non-federal funding for the payments described in the UPL demonstration. This guidance improved our ability to analyze supplemental payments and validate that aggregate supplemental payments for each class of provider ownership group do not exceed what Medicare would have paid for the services or, in an alternative approach that may be selected by the states, do not exceed the cost of providing those services.

We have also intensified our examination of SPAs proposing supplemental payments, and their associated funding arrangements, and have developed a greater understanding of how to ensure that payment and financing arrangements comply with statutory requirements. These reviews focus on ensuring more transparency for supplemental payments by requiring more comprehensive SPA language so that providers and other stakeholders can fully understand how providers will receive payment and any conditions on those payments. We are also asking more questions regarding states' assumptions about the value that proposed supplemental payments would bring to the Medicaid program, including in terms of improving access and quality of care outcomes, in our efforts to ensure that states' payment systems are consistent with section 1902(a)(30)(A) of the Act.

Although we made improvements to the parameters around aggregate payment levels as reflected in UPL demonstrations, there have been concerns from oversight entities, noted elsewhere in the preamble, regarding payments to individual providers, including concern that some governmental providers were being paid Medicaid payments far in excess of the costs incurred in providing the underlying services. In response to those concerns, we issued the ''Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership'' final rule with comment period in the May 29, 2007 **Federal Register** (72 FR 29748), which limited payments to any governmentally operated provider to the cost incurred for delivery of Medicaid services. The May 29, 2007 final rule with comment period was challenged by states and health care providers. After a series of Congressional moratoria against its implementation, Congress stated its sense that it should not be implemented. In 2010, the final rule was rescinded (75 FR 73972) and we have not moved forward with this or any similar approach.

We have previously recognized the need in other instances to obtain provider-level payment reporting. Section 1923(j) of the Act and its implementing regulations delineate annual DSH audit and reporting requirements. To ensure that Medicaid DSH payments are in compliance with federal statutory requirements, we published the 2008 DSH audit rule, which requires that states report and account for certain provider-level information on the hospitals receiving these payments. The rule also requires states to have their DSH payment programs independently audited to verify that the payments comply with applicable hospital-specific DSH limits. Such information includes reporting of supplemental payments and ensuring that such payments are factored into the hospital-specific DSH limit. However, this data set is limited in that it only includes reporting for those hospitals that receive Medicaid DSH payments and are due to us more than 3 years after the completion of each state plan rate year. Therefore, in § 447.288 of this proposed rule, to help ensure timely and comprehensive reporting on the Medicaid financing for all payments to hospitals, we are proposing to require the annual amount of total Medicaid DSH payments made to any provider be reported in the annual provider-level payment data report for this regulation, along with all Medicaid supplemental payments.

II. Provisions of the Proposed Rule

A. Proposed Provisions

1. Disallowance of Claims for FFP (§ 430.42)

Section 1116(d) and (e)(1) of the Act outline the disallowance reconsideration process and provide that a state may request administrative reconsideration of a disallowance if such a request is made within a 60-day period that begins on the date the state receives notice of the disallowance. However, the statute does not specify the format of the notice of disallowance or request for reconsiderations. We are proposing to amend § 430.42 to alter the means of communication with regard to the disallowance reconsideration process from one based on registered or certified mail to one based on electronic mail or another electronic system as specified by the Secretary. When § 430.42 as now in effect was finalized, certified mail was considered to be the optimal way to establish the dates on which a communication was sent and received, which is important to establish compliance with timeframes specified in regulation. However, email is a preferred form of communication today in the normal course of agency business and can be used to establish the time when a communication is sent and received, since email messages typically are transmitted near-instantaneously. Further, by eliminating mailing and paper costs, the use of email could slightly reduce the administrative burden associated with the disallowance process under § 430.42. As a result, we are proposing to revise all of the references to registered or certified mail or to ''written requests'' to make clear that such requests need not be in a physical, as opposed to an electronic format in § 430.42(b)(2)(i)(A) introductory text, (b)(2)(i)(B) and (C), (c)(3), (c)(4)(i), (c)(6), and (d)(1) to replace references to registered or certified mail with references to electronic mail (email) or another electronic system as specified by the Secretary. In addition, we propose to remove the word ''written'' from § 430.42(b)(2)(i)(A) and (B) to avoid a possible misunderstanding that the request must be in the form of a physical writing, since we propose to adopt an electronic process. The date that the communication is successfully sent or received by electronic mail (email) or electronic system as specified by the Secretary would be substituted for current references to the date that the communication was sent or received by registered or certified mail.

2. State Share of Financial Participation (§ 433.51)

We are proposing to amend § 433.51 to more clearly define the allowable sources of the non-federal share to more closely align with the provisions in section 1903(w) of the Act. In § 433.51(a) and (c), we are proposing to replace the current reference to ''public funds'' with ''state or local funds'' which is consistent with statutory language as in section 1903(w)(6)(A) of the Act. Public funds is not a phrase used in section 1903(w) of the Act, and the use of this phrase in regulation has caused confusion with respect to permissible sources of non-federal share. We are proposing to revise § 433.51(b) by similarly replacing the current reference to public funds and by specifying more precisely the funds that states may use as state share. Although we have applied the statutory language to our review and approval of state financing mechanisms, the term public funds in the regulatory text has created confusion among states, and has led to state requests to derive IGTs from sources other than state or local tax revenue (or funds appropriated to state university teaching hospitals), which is not permitted under the statute in section 1903(w)(6)(A) of the Act. The proposed amendment to paragraph (b) would clearly limit permissible state or local funds that may be considered as the state share to state general fund dollars appropriated by the state legislature directly to the state or local Medicaid agency; IGTs from units of government (including Indian tribes), derived from state or local taxes (or funds appropriated to state university

teaching hospitals), and transferred to the state Medicaid Agency and under its administrative control, except as provided in proposed § 433.51(d); or CPEs, which are certified by the contributing unit of government as representing expenditures eligible for FFP and reported to the state as provided in proposed § 447.206.

We are proposing these revisions to specifically align the allowable sources of the non-federal share with the statute. The proposed provisions would make clear that allowable state general fund appropriations under § 433.51(b)(1) are those made directly to the state or local Medicaid agency, and are differentiated from appropriations made to other units of government that otherwise may be tangentially involved in financing Medicaid payments through IGTs or CPEs. We would describe allowable IGTs and CPEs in proposed § 433.51(b)(2) and (3), respectively. The statute clearly differentiates between these sources of funds. Specifically, section 1903(w)(6)(A) of the Act provides that states generally may finance the state share using funds derived from state or local taxes (or funds appropriated to state university teaching hospitals) transferred from or certified by units of government within a state as the non-federal share of Medicaid expenditures. The phrase ''transferred from or certified by'' refers to the IGT and CPE, respectively, and the statute clearly indicates that those funding mechanisms must be derived from state or local taxes (or funds appropriated to state university teaching hospitals). The inclusion of the above reference to ''funds appropriated to state university teaching hospitals'' in § 433.51(b)(2) is a direct reference to language in section 1903(w)(6)(A) of the Act to more precisely implement the Act in this regulatory provision.

We are proposing to identify ''certified public expenditures'' specifically in regulation as an allowable source of state share in a manner consistent with section 1903 of the Act, and to describe the protocols states may use to identify allowable Medicaid expenditures associated with the use of a CPE as the source of non-federal share. Thus, we propose to include a reference in § 433.51(b)(3) to proposed § 447.206 to require that, for a state to use a CPE as a source of state share, the state must meet the requirements of proposed § 447.206, discussed in detail below, with respect to payments funded by the CPE. In particular, in § 447.206(b)(1), we propose that such payments, to a provider that is a unit of government, would be limited to the state or non-state government provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods.

Lastly, we are proposing to add paragraph (d) to this section to clearly indicate that state funds provided as an IGT from a unit of government but that are contingent upon the receipt of funds by, or are actually replaced in the accounts of, the transferring unit of government from funds from unallowable sources, would be considered to be a provider-related donation that is non-bona fide under §§ 433.52 and 433.54. This language is intended to implement the preclusion under section 1903(w)(6)(A) of the Act on the use of IGTs where the IGT is derived from a non-bona fide provider-related donation by making it abundantly clear that, as indicated in the statute, the IGT must come from state or local tax revenue (or funds appropriated to state university teaching hospitals), and any IGTs that are derived from, or are related to, non-bona fide provider-related donations would be prohibited.

3. General Definitions (§ 433.52)

The terms ''Medicaid activity'' and ''non-Medicaid activity'' are used in the proposed § 433.68(e)(3), discussed in detail below, in determining whether a health care-related tax program is generally redistributive in nature in accordance with section 1903(w)(3)(E)(ii)(I) of the Act. The definitions for ''Medicaid activity'' and ''non-Medicaid activity'' in this proposed rule would apply only to determining whether a state or other unit of government tax program is generally redistributive as required in section 1903(w)(3)(E)(ii)(I) of the Act. We are proposing to define ''Medicaid activity'' to mean any measure of the degree or amount of health care items or services related to the Medicaid program or utilized by Medicaid beneficiaries, including, but not limited to, Medicaid patient bed days, the percentage of an entity's net patient revenue attributable to Medicaid, Medicaid utilization, units of medical equipment sold to individuals utilizing Medicaid to pay for or supply such equipment or Medicaid member months covered by a health plan.

We are proposing to define ''non-Medicaid activity'' to mean any measure of the degree or amount of health care items or services not related to the Medicaid program or utilized by Medicaid beneficiaries. Such a measure could include, but would not necessarily be limited to, non-Medicaid patient bed days, percentage of an entity's net patient revenue not attributable to Medicaid, the percentage of patients not utilizing Medicaid to pay for health care items or services, units of medical equipment sold to individuals not utilizing Medicaid funds to pay for or supply such equipment, or non-Medicaid member months covered by a health plan.

We are proposing to define the term ''net effect'' to mean the overall impact of an arrangement, considering the actions of all of the entities participating in the arrangement, including all relevant financial transactions or transfers of value, in cash or in kind, among participating entities. The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities, and may include consideration of reciprocal actions without regard to whether the arrangement or a component of the arrangement is reduced to writing or is legally enforceable by any entity.

The term ''parameters of a tax'' is used in the proposed § 433.55(c), discussed in detail below, in determining whether a tax is health care-related as provided in section 1903(w)(3)(A) of the Act. We are proposing to define ''parameters of a tax'' to mean the grouping of individuals, entities, items or services, on which a state or unit of government imposes a tax.

Currently, § 433.52 specifies a definition of ''Provider-related donation'' that includes an introductory paragraph and three numbered paragraphs. We propose to redesignate paragraphs (2) and (3) as paragraphs (3) and (4), respectively, and to add a new paragraph (2). Proposed paragraph (2) would specify that any transfer of value where a health care provider or provider-related entity assumes an obligation previously held by a governmental entity and the governmental entity does not compensate the private entity at fair market value would be considered a donation made indirectly to the governmental entity. We are proposing that such an assumption of obligation need not rise to the level of a legally enforceable obligation to be considered a donation, but would be considered by examining the totality of the circumstances and judging the arrangement's net effect. For example, if a private provider assumes any contractual obligation, such as staffing costs for accounting services, of a non-state governmental entity without a corresponding transfer of value at market value, we would consider that to

be a provider-related donation from the private provider to the unit of government.

This proposal does not represent a new policy, but a clarification of current law designed to aid in preventing and, where they currently may exist, terminating impermissible financing practices involving provider-related donations. The current definition does not explicitly address circumstances involving the assumption of a governmental obligation, or our policy to determine the net effect of an arrangement in determining whether or not a donation has occurred.

We are also proposing to revise newly redesignated paragraphs (3) and (4) by changing the term ''health care related'' to ''provider-related'' to align with usage where provider-related donations are addressed throughout part 433, subpart B, and by changing the language in newly redesignated paragraph (4) from ''the percentage of donations the organization received from the providers during that period'' to ''the percentage of the organization's revenue during that period that was received as donations from providers or provider-related entities.'' We are proposing this change because we believe that this language is clearer and more transparent for states.

Some health care-related tax programs exclude certain items, services, or providers from taxation or impose variable rates. To do so, states or non-state units of government often divide the universe of entities subject to taxation into groups based on various attributes. We are proposing to define ''taxpayer group'' to mean one or more entities grouped together based on one or more common characteristics for purposes of imposing a tax on a class of items or services specified under § 433.56. This term is used in proposed § 433.56(e)(3), which is discussed in detail below, in determining whether or not a tax program is generally redistributive in nature, in accordance with section 1903(w)(3)(E)(ii)(I) of the Act.

4. Bona Fide Donations (§ 433.54)

Section 1903(w)(2)(B) of the Act provides that the Secretary may by regulation specify types of provider-related donations described in that subparagraph that will be considered to be bona fide provider-related donations. The statute requires that bona fide provider-related donations may have no direct or indirect relationship (as determined by the Secretary) to Medicaid payments to the provider, providers furnishing the same class of items and services as the provider, or to any related entity, as established by the state to the satisfaction of the Secretary. Accordingly, implementing regulations in § 433.54(b) require that bona fide provider-related donations must not be returned to the individual provider, provider class, or related entity under a hold harmless provision or practice as described in § 433.54(c). We are proposing to revise § 433.54(c)(3) to clarify the standard used to determine whether the state (or other unit of government) receiving a donation provides for any direct or indirect payment, offset, or waiver, such that the provision of that payment, offset, or waiver directly or indirectly guarantees the return of any portion of the donation to the provider (or other party or parties responsible for the donation). The clarification would make express our current policy of examining the totality of the circumstances that determine the net effect of an arrangement between the state (or other unit of government) and the provider, provider class, or provider-related entity responsible for the donation. Specifically, we are proposing that a direct guarantee of the return of all or part of a donation would be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the state (or other unit of government) and the provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or related entity will receive a return of all or a portion of the donation either directly or indirectly. As noted in the 2008 final rule on Health Care-Related Taxes, ''An indirect payment to the taxpayer would also constitute a direct guarantee'' (73 FR 9698). Section 433.68 at paragraphs (f)(1), (2) and (3) describe the three situations that constitute a direct hold harmless arrangement. Paragraphs (f)(3)(i)(A) and (B) detail the two ''prongs'' of the indirect hold-harmless guarantee test. These two ''prongs'' constitute the ''safe harbor threshold'' of 6 percent and the ''75/75'' test. The safe harbor threshold states that taxes that are under 6 percent of net patient revenue attributable to an assessed permissible class pass the indirect hold harmless test. If a tax collection exceeds the 6 percent net patient revenue threshold, the second prong is applied. This prong is known as the ''75/75'' test and states that CMS will consider an indirect hold harmless arrangement to exist if 75 percent or more of the taxpayers receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other state payments. If the tax fails this prong, CMS considers an indirect hold harmless arrangement to exist. Direct and indirect payments are used in the proposed rule in the same way as they are used currently in § 433.68(f). This clarification is designed to aid in preventing and, where they may currently exist, eliminating complex financing arrangements designed to obfuscate the fact that non-bona fide provider-related donations are the source of the non-federal share of certain Medicaid payments. This is consistent with our current policy, which we have applied in the past and discussed in SMDL 14–004 on impermissible provider-related donations. We are also proposing to revise paragraph (c)(3) to clarify that a singular party, not just multiple ''parties,'' could be responsible for a provider-related donation described in this paragraph.

5. Health Care-Related Taxes Defined (§ 433.55)

Section 1903(w)(3)(A) of the Act defines a health care-related tax as a tax that is (1) related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services; or (2) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities. In the case of (1), a tax is considered related to health care items or services if at least 85 percent of the tax burden falls on health care providers. Implementing regulations are codified in § 433.55(c). This proposed rule would amend § 433.55(c) by clarifying that differential treatment occurs when a tax program treats some individuals or entities that are providing or paying for health care items or services differently than (1) individuals or entities that are providers or payers of any health care items or services not subject to the tax or (2) other individuals or entities subject to the tax. Additionally, we would amend § 433.55(c) to clarify that we examine the parameters of the tax as defined by the state or other unit of government, as well as the totality of the circumstances relevant to which individuals, entities, items, or services are subject (and not subject) to the tax and at which rate, in determining whether the tax program involves differential treatment as provided in section 1903(w)(3)(A)(ii) of the Act. Finally, the proposed rule would also add paragraphs (c)(1) and (2) to clarify when CMS would consider the treatment of individuals or entities providing or paying for health care

items or services to be different from the treatment provided to other individuals or entities.

In the proposed § 433.55(c)(1), we propose to clarify that differential treatment for providers of health care items or services would occur where the state or other unit of government imposing the tax makes some individuals or entities providing or paying for health care items or services subject to the tax, but excludes others. For example, a state imposing a tax on telecommunication services and inpatient hospital services would constitute differential treatment because some providers or payers of health care items or services subject to the tax are being treated differently than providers or payers of health care items or services not subject to the tax. States or local units of government imposing a tax cannot structure the parameters of the tax in such a way as to include items or services that are not reasonably related so that only selected health care items or services are included in the tax while others are excluded. Selective incorporation would also occur when the state or other unit of government imposing the tax structures the parameters of the tax in a way that has the effect of specifically excluding or including certain providers of health care items or services from the tax. This would constitute differential treatment because it would have the same effect as selecting certain health care items or services for inclusion in the tax when such items or services are not reasonably related to the other items being taxed.

Additionally, we propose in § 433.55(c)(2) to specify that differential treatment would result when entities providing or paying for health care items or services are treated differently than other entities also included in the tax. For example, if the state taxes all businesses in the state, but places a higher tax rate on hospitals and nursing facilities than on other businesses, this would result in differential treatment.

We are concerned that taxes of the sort described in proposed § 433.55(c)(1) and (2) are not consistent with applicable statutory (and current regulatory) requirements because they may include individuals or entities providing or paying for health care items or services that receive high levels of reimbursement from Medicaid for such items or services, and that may receive a return of their tax costs in the form of increased Medicaid payments. In particular, we are concerned about tax programs that treat health care items or services that are mostly reimbursed by Medicaid differently than other health care items or services with low Medicaid reimbursement. For example, a statewide revenue tax of 5 percent of net revenue on all businesses in the state that includes only a subset of health care items or services that happens to be reimbursed heavily by Medicaid, such as HCBS, but which is designed to exclude other providers of health care items or services with lower rates of Medicaid reimbursement such as continuing care retirement facilities (CCRCs), would result in differential treatment. Any time a tax structure selectively incorporates a subset of health care items or services for inclusion in a tax and excludes others, we would consider this differential treatment, as reflected in proposed § 433.55(c)(1). Selective incorporation generally occurs in two situations: First, when the state or unit of government includes some, but not all, health care-related items or services and those items or services are not reasonably related to the other items being taxed. Second, when the state or other unit of government structures the parameters of the tax in such a way that has the effect of such selective incorporation described above. Reasonably related means there exists a logical or thematic connection between the items or services being taxed. Examples of such a connection include, but are not limited to, industry, such as electronics; geographical area, such as city or county; net revenue volume; or number of employees.

Additionally, any time the tax treats individuals or entities providing or paying for health care items or services differently than other entities also included in the tax, we would also consider this to be differential treatment, as reflected in proposed § 433.55(c)(2). We note that the examples provided in these proposed paragraphs do not constitute an exhaustive list of all possible manifestations of differential treatment. Other circumstances constituting differential treatment for health care items or services, or entities providing or paying for health care items or services, would result in the tax being considered health care-related based on the differential treatment provisions in § 433.55(c).

The proposed language related to selective incorporation does not mean that the state or other unit of government must tax every provider of health care items or services within its jurisdiction to avoid its tax being considered health-care related in situations where less than 85 percent of the tax burden falls on health care items or services. It does mean that the state or other unit of government cannot include in or exclude from the tax only certain providers, or a class or classes of providers, by its own specification of the parameters of the tax. In addition, the state cannot structure the parameters of the tax in such a way so as to have the same effect of carving out or in only certain providers, or a class or classes of provider.

6. Classes of Health Care Services and Providers Defined (§ 433.56)

Section 1903(w)(7)(A)(ix) of the Act provides that the permissible classes of health care items and services include such other classifications consistent with section 1903(w)(7)(A) of the Act as the Secretary may establish by regulation. In addition to the specific classifications that Congress identified in statute, current regulations in § 433.56(a) specify certain additional classes established by the Secretary. We are proposing to add a new class of health care items and services to the list of permissible classes at § 433.56(a) by redesignating paragraph (a)(19) as paragraph (a)(20), revising paragraph (a)(18), and adding a new paragraph (a)(19). We propose to strike ''and'' from paragraph (a)(18), to accommodate the proposed paragraph (a)(20). In new proposed paragraph (a)(19), we would permit states and units of local government to impose taxes on services of health insurers beside those already identified in paragraph (a)(8) of the same section.

We have become aware that a number of states may be imposing taxes on health insurers in the form of a tax on health insurance premiums or volume of services. Section 1903(w)(7)(A)(ix) of the Act delegates to the Secretary the power to specify such other classification of health care items and services consistent with the paragraph as the Secretary may establish by regulation. We are proposing to expand the permissible class list to provide states with additional flexibility, while maintaining the fiscal integrity of the Medicaid program by ensuring that the proposed new permissible class would not be limited to items or services that are primarily or exclusively provided or paid for by the Medicaid program. Taxes imposed on health care items or services or providers of such items or services financed primarily or exclusively by Medicaid would harm the fiscal integrity of the Medicaid program by imposing a higher tax burden on the program and would not be generally redistributive as required by section 1903(w)(3)(E)(ii)(I) of the Act. Specifically, we are proposing to establish services of health insurers,

besides services of MCOs (including HMOs and PPOs), as a new permissible class. Services of MCOs (including HMOs and PPOs) are already a permissible class of services identified in § 433.56(a)(8). Some examples of possible metrics that could be used to assess a tax on services of health insurers include health care premiums, covered lives, or revenue. The proposed class would include health insurers offering plans to Medicaid beneficiaries under a section 1115 demonstration for a premium assistance program to such beneficiaries to purchase qualified health plans through the Health Insurance Exchange. We are seeking comment on the exact scope of this permissible class to ensure all appropriate services of health insurers are included within this class. As with other permissible classes, taxes imposed on this proposed category of health care services would be subject to applicable legal requirements, including the broad-based requirements in § 433.68(b)(1), the uniformity requirements in § 433.68(b)(2), and the hold harmless provisions in § 433.68(f).

The preamble of the August 1993 final rule listed criteria that should be met by any additional class of health care items and services under consideration to be added to the permissible classes under section 1903(w)(7)(A) of the Act. The preamble stated three criteria: The revenue of the class is not predominantly from Medicaid and Medicare (not more than 50 percent from Medicaid and not more than 80 percent from Medicaid, Medicare, and other federal programs combined); the class must be clearly identifiable, such as through designation for state licensing purposes, recognition for federal statutory purposes, or being included as a provider in state plans; and the class must be nationally recognized and not be unique to a state (58 FR 43162). We believe that the class of providers of health care items or services which we are proposing to add to § 433.56 meets all of these requirements. First, according to the most recent data available from the U.S. Census Bureau (See Health Insurance Coverage in the United States, September 12, 2018, Report Number P–60 264, Edward R. Berchick, Emily Hood, and Jessica C. Barnett, p. 1–2), 67.2 percent of individuals in the United States that are insured have private health insurance, whereas 37.7 percent have government coverage including 19.3 percent that have Medicaid and 17.2 percent that have Medicare. In addition, not all Medicaid or Medicare beneficiaries must pay premiums or cost sharing, and the amounts that they do pay, when required, are generally limited by federal statute and regulation and typically are lower than premiums and cost sharing amounts paid by enrollees in private insurance coverage. As a result, we do not believe that revenue from the proposed class, services of health insurers besides services of MCOs (including HMOs and PPOs) is predominantly from Medicaid and Medicare. Specifically, we believe that such revenue is not more than 50 percent from Medicaid and not more than 80 percent from Medicaid, Medicare, and other federal programs combined. Second, each state already defines and regulates health insurers in the state, through state law. As a result, the class is clearly identifiable. To the extent that state law specifically includes or excludes certain types of issuers of health insurance policies as health insurers, we propose deferring to the state in determining which such entities are included within the proposed class and which are not. For example, certain groups of businesses may band together to offer health insurance plans to their employees, a practice known as association health plans under section 3(5) of the Employee Retirement Income and Security Act (ERISA) (Pub. L. 93–406, enacted September 2, 1974). The degree to which an issuer of an association health plan is considered to be a health insurer depends on state law. Finally, health insurers exist nationwide, and are not particular to any individual state. Neither we (that is, CMS, either with respect to our administration of Medicare or Medicaid), the state Medicaid agency, or any agency involved in administering title XVIII, title XIX, or title XXI is considered to be a health insurer in terms of the proposed class to be added at § 433.56. As a result, the proposed class meets all of the criteria specified in the 1993 final rule and is appropriate to add to the classes of health care items and services upon which states may impose health care-related taxes without a reduction in FFP, subject to all applicable federal statutory and regulatory requirements.

7. Permissible Health Care-Related Taxes (§ 433.68(e) and (f))

Section 1903(w)(3)(E)(ii)(I) of the Act provides that the Secretary shall approve a state's application for a waiver of the broad based and/or uniformity requirements for a health care-related tax, if the state demonstrates to the Secretary's satisfaction that the tax meets specified criteria, including that the net impact of the tax and associated Medicaid expenditures as proposed by the state is generally redistributive in nature. Implementing regulations in § 433.68(e) specify a statistical test for evaluating whether a proposed tax is generally redistributive: If the state is seeking only a waiver of the broad based requirement, paragraph (e)(1) specifies a test referred to as ''P1/P2'' described above, while a state seeking a waiver of the uniformity requirement or both the broad-based and uniformity requirements must meet the test specified in paragraph (e)(2), referred to as ''B1/B2'', also described above. Although these tests were designed to ensure that a proposed tax is generally redistributive in accordance with section 1903(w)(3)(E)(ii)(I) of the Act, we have found that these tests alone have been insufficient in some circumstances as described above. As a result, we are proposing to add § 433.68(e)(3), to ensure that a proposed tax is truly generally redistributive.

Specifically, we are proposing to amend § 433.68(e) to provide that a proposed tax must satisfy both paragraph (e)(3) of this section, and, as applicable, paragraph (e)(1) or (2) of this section. At paragraph (e)(3), we propose that a tax must not impose undue burden on health care items or services paid for by Medicaid or on providers of such items and services that are reimbursed by Medicaid. We would consider a tax to impose undue burden under this paragraph if taxpayers are divided into taxpayer groups and any one or more of the following conditions apply: (1) The tax excludes or places a lower tax rate on any taxpayer group defined by its level of Medicaid activity than on any other taxpayer group defined by its relatively higher level of Medicaid activity; (2) within each taxpayer group, the tax rate varies based on the level of Medicaid activity, and the tax rate imposed on any Medicaid activity is higher than the tax rate imposed on any non-Medicaid activity (except as a result of excluding from taxation Medicare revenue or payments as described in § 433.68(d)); (3) the tax excludes or imposes a lower tax rate on a taxpayer group with no Medicaid activity than on any other taxpayer group, unless all entities in the taxpayer group with no Medicaid activity meet at least one of four specified exceptions; or (4) the tax excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the taxpayer group having no Medicaid

activity or relatively lower Medicaid activity than any other taxpayer group. These four conditions represent specific parameters of tax structures that, in addition to those identified through the P1/P2 and B1/B2 test, inherently result in undue burden on the Medicaid program. CMS considers taxes that pose an undue burden on the Medicaid program to be inherently not generally redistributive because they impose a higher tax burden on health care items or services, or providers of such items and services, that are financed by Medicaid than those not financed by Medicaid, as explained in the preamble to the August 1993 final rule, discussed above.

We are proposing to require states to ensure compliance with the proposed requirement at paragraph (e)(3) to avoid placing an undue burden on the Medicaid program beginning on the effective date of any final rule for tax waivers that have not yet been approved before the effective date of any final rule. For tax waivers approved before the effective date of any final rule, we are proposing that states must come into compliance with this requirement when submitting a new waiver request. As described below, in § 433.72, we are proposing to add new paragraphs (c)(3) and (4) to specify the date on which a waiver approved under § 433.72(b) will no longer be effective. We are proposing that an approved waiver would have a 3-year term; for a waiver approved before the effective date of the final rule the 3-year term would run from the effective date of the final rule. A state would be free to apply for renewal of an expired or expiring waiver, subject to the same approval criteria applicable to an initial waiver request under § 433.72(b). As a result, for existing tax waivers, we are proposing to require states to come into compliance with proposed § 433.68(e)(3) when they submit a new tax waiver request, which we are proposing would be no later than 3 years after the effective date of any final rule, depending on whether the state makes any substantial changes to the health care-related tax as specified in proposed § 433.72(d). We believe that this time frame would ensure our goal of supporting the fiscal integrity of the Medicaid program while giving states the necessary time to comply with the proposed regulatory amendments.

It is important to note that nothing in this proposed rule would interfere with states' permissible use of tax revenues to fund provider payments or reliance on such use of tax revenues to justify or explain the tax in the legislative process, as provided in section 1903(w)(4) of the Act. Tax structures that place an undue burden on Medicaid, however, would not be considered to be generally redistributive for the purposes of § 433.68(e). We seek comment on our proposed amendments to § 433.68(e), and on additional conditions that could result in a tax program imposing undue burden on the Medicaid program, and therefore, failing to be generally redistributive in nature that are not included in this proposed list.

Section 1903(w)(1)(A)(iii) of the Act states that the total amount expended during the fiscal year as medical assistance under the state plan shall be reduced by the sum of any revenues received by the state during the fiscal year from a broad-based health care-related tax if there is in effect a hold harmless provision with respect to the tax. Section 1903(w)(4)(C) of the Act states that there is in effect a hold harmless provision with respect to a health care-related tax if the state or other unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold the taxpayer harmless for any portion of the costs of the tax. Section 433.68(f)(3) echoes this language. The proposed rule would add a net effect standard to § 433.68(f)(3). This proposed change represents a clarification of existing policy and would not impose any new obligations or place any new restrictions on states that do not currently exist. The language added by the proposed rule would specify that a direct or indirect hold harmless guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the state (or other unit of government) and the taxpayer results in a reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount as discussed above. We propose that the net effect of such an arrangement may result in the return of all or any portion of the tax amount, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.

Proposed § 433.68(f)(3) aims to thwart efforts by states to skirt hold harmless provisions by paying supplemental payments to private entities, who then pass these funds on to other private entities that have lost gross revenue due to a health care-related tax. The use of an intermediary does not change the essential nature of the transaction: That it is a payment made by a state or unit of government to a provider that holds that provider harmless for the cost of the tax. While states are free to impose broad-based and uniform health care-related taxes, or generally redistributive health care-related taxes that meet applicable requirements for a waiver of either or both of these requirements, to fund the non-federal share of Medicaid expenditures, states may not do so in a way that guarantees to return all or part of the cost of the tax to the taxpayers. The proposed language adding the net effect standard to the direct hold harmless guarantee test at § 433.68(f)(3) clarifies to states the range of permissible tax and reimbursement arrangements for health care-related taxes. Such clarifying language allows states and CMS to work more harmoniously together by solidifying a shared understanding regarding what constitutes a guarantee to hold taxpayers harmless for the cost of a health care-related tax and reduces the likelihood of disagreement concerning the interpretation of the regulation. As such, the proposed amendment would allow states to operate their Medicaid financing programs with greater clarity and consistency than before.

We seek comment on our proposed amendments to § 433.68(f)(3). Additionally, we are soliciting comments on other qualitative or quantitative measures that could further safeguard the fiscal health and integrity of the Medicaid program through modifications to the provisions of § 433.68.

8. Waiver Provisions Applicable to Health Care-Related Taxes (§ 433.72)

In § 433.72, we are proposing to add new paragraphs (c)(3) and (4) to specify the date on which a waiver approved under paragraph (b) of this section would no longer be effective. We are proposing that an approved waiver should have a 3-year term; for a waiver already approved before the effective date of the final rule, if this proposal is finalized, the 3-year term would run from the effective date of the final rule. A state would be free to apply for renewal of an expired or expiring waiver, subject to the same approval criteria applicable to an initial waiver request under § 433.72(b). We are proposing a 3-year limit to ensure the tax program continues to meet all applicable requirements under part 433, subpart B, including whether or not the tax program continues to meet generally redistributive requirements at § 433.68(e)(1) and (2) and proposed paragraph (e)(3).

We are proposing to limit waiver approvals to 3 years because the provider data that states provide to CMS for use in the statistical tests at § 433.68 and the providers in the class subject to the waiver change over time. As a result,

while a tax may be generally redistributive when the state first requests the waiver, it may cease to be so as the composition of the providers or payers, or the volume of items or services subject to the tax changes. In an effort to ensure consistent fiscal oversight of the non-federal share of Medicaid expenditures and to ensure that health care items and services, and providers of health care items or services, financed by Medicaid are not taxed more heavily than those not financed by Medicaid, we believe that this proposed time period would aid in ensuring state tax programs are and remain consistent with section 1903(w)(3)(E)(ii) of the Act. This provision establishes that the Secretary will approve waivers if the state establishes to the satisfaction of the Secretary that the net impact of the tax is generally redistributive in nature and the amount of the tax is not directly correlated to Medicaid payments. We believe it is necessary for the proper and efficient operation of the Medicaid program to establish that a tax for which a state seeks a waiver meets statutory requirements not just when the waiver is initially approved, but on an ongoing basis as well. We propose to allow states with already existing health care-related tax waivers 3 years from the effective date of the final rule, as stated in proposed § 433.72(c)(4), to seek reapproval of their waivers, in an effort to provide states with sufficient time to evaluate and, as may be necessary, modify existing tax programs to comply with applicable requirements.

We are proposing to add new § 433.72(d), to ensure ongoing compliance of tax waivers with the original conditions of the waiver approval. In this proposed paragraph, we would specify that, for a state to continue to receive tax revenue (within specified limitations) under an approved waiver without a reduction in FFP as would otherwise be required under section 1903(w)(1)(A)(ii) of the Act and § 433.70, the state must: (1) Ensure that the tax program for which CMS approved the waiver continues to meet the waiver conditions identified in § 433.72(b)(1) through (3) at all times during which the waiver is in effect; and (2) request a new waiver if the state or other unit of government imposing the tax modifies the tax program in specified ways. We propose that, if the state or other unit of government imposing the tax modifies the tax in a non-uniform manner, meaning the change in tax or tax rate does not apply in an equal dollar amount or percentage change to all taxpayers, the state would be required to request a new waiver subject to effective date requirements in § 433.72(c). If the state or other unit of government imposing the tax modifies the criteria for defining the taxpayer group or groups subject to the tax, the state would be required to request a new waiver subject to effective date requirements in § 433.72(c). As with the 3-year waiver validity period at proposed § 433.72(c)(3) and (4), the proposed new requirements at paragraph (d) would help ensure that the tax remains generally redistributive while the waiver is in effect, since these changes could affect the determination whether it meets applicable requirements. States would be permitted to make changes that would not affect the compliance of the tax with all applicable broad-based and uniformity standards (including waiver standards) without receiving a new approval of a tax waiver from CMS. However, states wishing to make changes to their tax structures that modify any of the proposed, specified elements would be required to submit a new tax waiver request and obtain approval from us before beginning to collect such a tax. States may not make changes to the tax structure that result in taxpayers being held harmless for some or all of the cost of the tax without experiencing a reduction in their amount of medical assistance expenditures for purposes of claiming FFP as specified by section 1903(w)(1)(A) of the Act.

9. When Discovery of Overpayment Occurs and its Significance (§ 433.316)

Section 1903(d)(2)(C) of the Act provides that, when an overpayment by a state is discovered, the state has a 1-year period to recover or attempt to recover the overpayment before an adjustment is made to FFP to account for the overpayment. Currently, regulations in § 433.316 provide for determining the date of discovery of an overpayment, which is necessary to determine the statutory 1-year period, in three distinct cases: When the overpayment results from a situation other than fraud, under § 433.316(c); when the overpayment results from fraud, under § 433.316(d); and when the overpayment is identified through a federal review, under § 433.316(e). It is not explicitly clear in the current regulations how the date of discovery is determined when an overpayment is discovered through the annual DSH independent certified audit required under § 455.304. Therefore, we believe an amendment is appropriate to specify the date of discovery of overpayments as it relates to the annual DSH independent certified audit. Accordingly, we are proposing to redesignate paragraphs (f), (g), and (h) as paragraphs (g), (h), and (i), respectively, and to add new proposed paragraph (f). In new paragraph (f), we are proposing that in the case of an overpayment identified through the DSH independent certified audit required under part 455, subpart D, we will consider the overpayment as discovered on the earliest of the date that the state submits the DSH independent certified audit report required under § 455.304(b) to CMS, or any of the dates specified in § 433.316: Paragraph (c)(1) (the date on which any Medicaid agency official or other state official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery); paragraph (c)(2) (the date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency); and paragraph (c)(3) (the date on which any state official or fiscal agent of the state initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing).

10. State Plan Requirements (§ 447.201)

We are proposing to add new § 447.201(c) to specify that the state plan may not provide for variation in FFS payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration, or federal matching rate available for services provided to a beneficiary's eligibility category under the plan. As discussed below, this provision would implement sections 1902(a)(4) and (a)(30)(A) of the Act, and codify our current practice, by prohibiting variations in service payments on the basis of available FFP.

States seeking to increase payments only on the basis of a higher available FFP for the relevant beneficiary population creates inequity in the Medicaid program. By approving Medicaid state plan payments, we are making an administrative decision that the payment rates are consistent with section 1902(a)(30)(A) of the Act; specifically, that such payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. In the absence of an access issue, it would not be consistent with efficiency and economy to pay providers more, only because the federal matching rate is increased with respect to certain categories of beneficiaries. In addition,

where payment rates under the state plan do result in insufficient access for Medicaid beneficiaries, the state must increase rates to rectify the access problem for all Medicaid beneficiaries, not only those for whom the statute provides for an increased FMAP.

We have allowed states to set payment rates based on higher costs for the delivery of care (for example, difference in acuity or particular health needs); however, we have not allowed states to pay higher rates based on policies that are unrelated to actual increases in the cost of furnishing services to the relevant beneficiaries. For example, we have allowed states to pay higher rates to a provider based upon a higher provider qualifications, which may be equated with a higher cost of furnishing services, but that payment difference is for all Medicaid beneficiaries that receive services provided by that provider. Similarly, we have not allowed states to target higher payments based on eligibility status or enhanced matching rates, since those factors are not established to have any relationship to the cost of delivering care. Rates that are structured without regard to service costs and care delivery are not economic and efficient and are inconsistent with section 1902(a)(30)(A) of the Act. This proposed provision is intended to make clear that variation in payment rates solely on the basis of FFP is prohibited, as it would be inconsistent with efficiency and economy to allow states to pay providers more, only because such payments can be funded by drawing down additional federal dollars at a marginally increased cost to the state (and at net savings to the state, versus the costs the state would incur if the relevant beneficiary population qualified for standard FMAP). We believe that this proposed provision is necessary to ensure the proper and efficient operation of the Medicaid state plan, in a manner that complies with the requirements of section 1902(a)(4) and (a)(30)(A) of the Act.

This proposed approach would be consistent across both FFS and managed care. Specifically, in the 2016 Medicaid managed care final rule, we articulated in § 438.4(b)(1) that any differences among capitation rates according to covered populations must be based on valid rate development standards and not be based on the FFP associated with the covered populations (81 FR 27566).

We also considered proposing a rule that would require states to pay the same rate to a facility for all beneficiaries, unless the state could demonstrate that different case mixes or health care needs, or other reasons consistent with economy, efficiency, quality of care, and access justified paying a different rate for a different group of beneficiaries. We decided instead to propose that the plan must provide for no variation in FFS payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration project, or FMAP rate available for services provided to an individual in the beneficiary's eligibility category, because, as stated above, where payment rates under the state plan do result in insufficient access for Medicaid beneficiaries, the state must increase rates to rectify the access problem for all Medicaid beneficiaries, not only those for whom the statute provides for an increased FMAP. We seek comment on proposed § 447.201.

11. Payments Funded by Certified Public Expenditures Made to Providers That are Units of Government (§ 447.206)

We are proposing to add § 447.206 to codify longstanding policies implementing the following sections of the statute: Section 1902(a)(4) for proper and efficient operation of the state plan; section 1902(a)(30)(A) requiring that payments be economic and efficient; and section 1903(w)(6)(A) permitting states to use CPEs, which are expenditures certified by units of government within a state, as a source of non-federal share. The specific standards for states to document Medicaid expenditures that units of government may certify through a CPE for a claim for FFP has not previously been defined in regulation. While CPEs are not necessarily ''payments'' in the usual sense of the term, instead they are transactions which take the place of regular FFS payment. However, we refer to payments generally to mean the total computable amount the provider receives for performing Medicaid services. We are proposing in § 447.206(a) to specifiy that § 447.206 applies only to payments made to providers that are state government providers or Non-state government providers, as defined in proposed § 447.286, where such payments to such providers are funded by a CPE, as specified in § 433.51(b)(3), as proposed by this rule. Further, we are proposing in § 447.206(b)(1) that CPE-funded payments made to state government providers or non-state government providers would be limited to reimbursement not in excess of the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, to Medicare cost principles specified in 42 CFR part 413.

In the case of CPEs, states allow providers that are state or local government entities to expend funds in order to provide services to Medicaid beneficiaries. These providers document that the monies were spent furnishing covered services to Medicaid beneficiaries and certify their expenditures to the state. Without any funds actually changing hands between the state or local government entity that is the provider, and the Medicaid agency (such as via an IGT), and without the state appropriating associated funds directly to the Medicaid agency, the state uses the amount of the CPE as non-federal share to claim FFP.

To document the expenditure, we are proposing to add new § 447.206(b), which would define general rules for these CPE cost protocols. We are proposing to codify our practice of relying upon the cost allocation principles in federal regulations in 45 CFR part 75, 2 CFR part 200, and, as applicable, Medicare cost principles specified in part 413, as the methods and principles to identify Medicaid program expenditures eligible to support a CPE. First, we propose that Medicaid payments funded by a CPE would be limited to reimbursement not in excess of the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable methods of identifying and allocating costs to Medicaid, as stated above. We recommend that states use the Medicare cost reports as the basis for determining Medicaid cost where available for an applicable service (for example, Medicare 2552–10 Hospital Cost Report or the Medicare 2540–10 Skilled Nursing Facility Cost Report). However, since a number of states already have developed and currently use a state-developed cost report that is based on the Medicare cost report, meaning that the state cost report uses data taken from the calculations in the Medicare cost report, we are not requiring that states only use the Medicare cost report as we do not desire to increase state burden in this area.

Section 447.206(b)(2), as proposed, would provide that the state must establish and implement documentation and audit protocols, which must include an annual cost report to be submitted by the state government provider or non-state government provider to the state agency that documents the provider's costs incurred in furnishing services to Medicaid beneficiaries during the provider's fiscal

year. Section 447.206(b)(3) would provide that only the certified amount of the expenditure may be claimed for FFP. The claimed amount is limited because the CPE must only represent amounts that were spent providing the Medicaid services, as authorized by sections 1903(a)(1) and (w)(6)(A) of the Act, which authorize federal matching funds for state Medicaid expenditures and allows funds certified by units of government within a state as the non-federal share of expenditures, respectively.

Proposed § 447.206(b)(4) would require the certifying entity of the CPE to receive and retain the full FFP associated with the Medicaid payment, consistent with the cost identification protocols in the Medicaid state plan and in accordance with proposed § 447.207. We are proposing to require that certifying entities receive and retain the FFP a state claims from CMS to prevent inappropriate recycling of federal funds and any other potential redirection of federal funds that would be prohibited under the statute. In recent years, we have found that states have been drawing down FFP to match CPEs, retaining the federal share and using these federal funds as the non-federal share for other Medicaid payments. This practice is not consistent with the existing § 433.51(c), which generally prohibits the use of federal funds to match other federal funds. When a state makes a claim for FFP on a medical assistance expenditure, that claim for the FFP is singularly for that medical assistance expenditure and a recognition of the state and federal partnership of the Medicaid program. To claim and receive FFP for an expenditure, and to reuse that FFP to claim additional federal matching funds or to otherwise redirect the FFP to pay costs unrelated to the expenditure for which the FFP was claimed results, in effect, in the federal government alone funding the full Medicaid payment to the provider that originally certified the CPE, or, viewed another way, covering costs ineligible for FFP. Such a result is not consistent with sections 1902(a)(2), 1902(a)(4), and 1903 of the Act.

Proposed § 447.206(c) would specify other criteria for states when a CPE is used to fund a Medicaid payment. Under paragraph (c)(1), the state would be required to implement processes by which all claims for medical assistance would be processed through the MMIS in a manner that identifies the specific Medicaid services provided to specific enrollees. Paragraph (c)(2) would provide that the state is required to utilize most recently filed cost reports as specified in proposed paragraph (b)(2) to develop interim payments rates, which may be trended by an applicable health care-related index. Interim rates are rates that reflect the provider's expected cost of providing services throughout the year. Requiring states to establish interim rates ensures that providers would receive payments throughout the year, calculated to closely reflect the provider's expenditures in furnishing services to Medicaid beneficiaries. This would provide cash flow to support the provider's ongoing operations, and, with the interim rates based on the provider's most recent filed cost reports (trended forward by an applicable health care-related index, at state option), would potentially minimize reconciliation payments to providers (in the case of underpayment) or collections from providers (in the case of overpayments) at the end the year during the reconciliation process. The term ''health care-related index'' means a trend factor which would project increases or decreases in expected costs, so as to minimize potential over- or under-payments to the provider certifying the CPE. One such index is the CMS Market Basket, which we publish for purposes related to the Medicare program. However, states could also propose to use an alternative health-care related index, provided the state demonstrates that the alternative is likely to reliably project increases or decreases in providers' costs of furnishing covered services to Medicaid beneficiaries in the upcoming year. In reviewing a state-proposed health-care related index, we would require the state to identify the index in the state plan and provide a justification for the use of this index rather than other national indices, such as the CMS Market Basket.

We propose that reconciliations would be performed by reconciling payments made during the year based on the interim Medicaid payment rates, to the provider's filed cost report for the state plan rate year in which interim payments were made. Section 455.301 defines the state plan rate year as the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding DSH payments, as well as all other Medicaid payment rates. The period usually corresponds with the state's fiscal year or the federal fiscal year but can correspond to any 12-month period defined by the state as the Medicaid state plan rate year (73 FR 77951). Proposed paragraph (c)(3) would require that final settlement be performed annually by reconciling any interim payments to the finalized cost report for the state plan rate year in which any interim payment rates were made. Final settlement would be required to be made no more than 24 months from the relevant cost report year end, except under circumstances identified in 45 CFR 95.19. The 24-month period was chosen to comply with the generally applicable 2-year time limit for claiming payment for expenditures in 45 CFR 95.7.

During the reconciliation and final settlement process, we expect that the state would receive the provider's cost report and review the reported expenditures via a desk review process. As part of the desk review, the state would gather, organize, and analyze the provider's cost report, including by comparing current period expenditures to prior period expenditures to identify audit risks. During the desk review, we expect that the state may request explanations of or adjustments to the reported cost based upon generally accepted accounting principles (GAAP). Upon finalization of the desk review, the state would notify the provider of the final determination of total cost. Once the state has made a final determination of the provider's final cost, if the provider's actual total cost is not equal to the sum of its interim rate payments for the period, one of two actions may occur. If the provider has been underpaid, meaning the total interim rate payments were less than the total calculated cost amount, the state may draw down and pay to the provider FFP associated with the total computable expenditure certified by the provider as a prior period adjustment to the CMS 64, equal to the difference between the total interim payments and total cost. In the event the provider was overpaid, meaning the interim rate payments exceeded the provider's total cost, the state would calculate the overpayment, which would be equal to the difference between the total interim payments and the provider's total cost, and return the federal share of that amount to CMS as a prior period adjustment under part 433 subpart F. In the event of an overpayment, the state is obligated to return the FFP whether or not the state seeks a return of payment from the provider as articulated in § 433.316. All of these steps would establish an auditable basis for the state's claims for FFP associated with the CPEs, as contemplated under section 1902(a)(42)(A) of the Act, which requires that the state plan must provide that the records of any entity participating in the plan and providing

services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan.

Proposed § 447.206(d) would specify requirements for the state plan when the state proposes to use a CPE to fund a Medicaid payment. We propose that, if CPEs are used as a source of non-federal share under the state plan, the state plan would be required to specify cost protocols in the service payment methodology applicable to the certifying provider, such protocols would be required to meet all of the following criteria: (1) Identify allowable cost using either a Medicare cost report, or a state-developed Medicaid cost report prepared in accordance with the cost principles in 45 CFR part 75 and 2 CFR part 200; (2) define an interim rate methodology that would be used to pay a provider on an interim basis; (3) describe an attestation process by which the certifying entity would attest that the costs are accurate and consistent with 45 CFR part 75 and 2 CFR part 200; (4) include, as necessary, a list of the covered Medicaid services being furnished by each provider certifying a CPE; and (5) define a reconciliation and settlement process consistent with proposed § 447.206(c)(3) and (4). Regarding the inclusion in paragraph (d)(4) of a list of the covered Medicaid services being furnished by each provider, CMS is referring to instances where the services included in a cost report either extend across multiple Medicaid benefit categories or do not encompass all services within a benefit category. In such circumstances, we believe that this information is necessary to determine the services for which FFP is available. For example, in a setting where some but not all services within a Medicaid benefit category are furnished, such as a residential rehabilitation hospital that does not furnish all inpatient hospital services, the state would be required to document the services for which the state will be claiming FFP with respect to the provider. In most settings where the provider certifies a CPE, this step is not necessary, since the services furnished by the provider certifying the CPE will be coextensive with a Medicaid benefit category (for example, the ''inpatient hospital services'' Medicaid benefit category typically is coextensive with the services furnished by an inpatient hospital that might certify a CPE).

We are soliciting comment on our overall proposal, including the proposed cost reporting and process requirements, state plan requirements, and whether to require the use of the Medicare cost report where one exists for an applicable service for which the provider certifies a CPE. We believe requiring the use of a Medicare cost report where one exists for CPE protocols would allow for a consistent application of allowable cost principles, however, Medicare cost reports only exist for a relatively small number of services that states may cover in their Medicaid programs and requiring the use of Medicare cost reports would remove some state flexibility in determining the appropriate cost reporting mechanism for providers certifying CPEs in the state's Medicaid program.

12. Retention of Payments (§ 447.207)

In § 447.207, we propose to require that payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved state plan (or the approved provisions of a waiver or demonstration, if applicable). This provision is intended to implement sections 1902(a)(4) and (a)(32) of the Act. These provisions respectively require that the state plan for medical assistance provide such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and generally provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise, unless certain enumerated exceptions apply as described in more detail below. Payment arrangements that comply with an exception in section 1902(a)(32) of the Act and the implementing regulation in § 447.10 would not be deemed out of compliance with this proposed provision.

The Secretary would determine compliance with this provision by examining any associated transactions that are related to the provider's total computable Medicaid payment to ensure that the state's claimed expenditure, which serves as the basis for FFP, is consistent with the state's net expenditure, and that the full amount of the non-federal share of the payment has been satisfied. The term ''state's net expenditure'' in this section means a state's Medicaid expenditure, less any returned funds or contributions from the provider to the state, related to the Medicaid payment. This view of a return of any portion of a Medicaid payment is consistent with the treatment of provider-related donations in § 433.54, particularly paragraph (e) of that section which states CMS will deduct the amount of an impermissible provider-related donation from a state's medical assistance expenditures before calculating FFP (73 FR 9698). Consideration for the state's net expenditure would include a review of potential ''hold harmless'' arrangements as described in § 433.54(c), which provides that an impermissible hold harmless practice exists if the Medicaid payment is positively correlated to a donation, varies based only on the amount of a donation (including if payment is conditioned upon the receipt of a donation), or directly or indirectly guarantees to return any portion of a donation to the donating provider (or other party responsible for the donation), which implements section 1903(w)(2)(B) of the Act. We have noted circumstances in some states where participation in a Medicaid supplemental payment under the state plan is conditioned upon the state receiving a portion of that payment back, whether as a direct payment from the provider or netted from payments to the provider where the state retains a portion of the provider's payment before sending the remaining payment to the provider.

We anticipate that ''associated transactions'' may include, but would not necessarily be limited to, the payment of an administrative fee to the state as a fee for processing provider payments or IGTs. For example, in some states, we have found that the Medicaid agency has charged a percentage administrative fee for each Medicaid claim that was processed. Essentially, the state was charging providers for submitting claims to the Medicaid program, and since the administrative charge was based on claims volume and amount of Medicaid payment, this practice amounted to a tax on Medicaid claims for services. States are already able to, and often do, claim administrative match for Medicaid claims processing costs; states should be using the appropriate mechanisms for claiming where authority exists and not unnecessarily shifting costs to the Medicaid providers. We propose that in no event could administrative fees be calculated based on the amount a provider receives through Medicaid payments or amounts a unit of government contributes through an IGT as funds for the state share of Medicaid payments. Structuring an administrative fee in this way would be tantamount to a Medicaid-only provider tax, which is not allowable under § 433.55, and would be expressly prohibited under the proposed § 447.207(a). Conversely, if

a state charged a flat fee for claims processing that did not vary based on the volume of claims or amount of Medicaid payments processed, the payment of such a fee would not be considered an associated transaction. Likewise, the use of Medicaid revenues to fund payments that are normal operating expenses of conducting business, such as payments related to taxes (including permissible health-care-related taxes), fees, or business relationships with governments unrelated to Medicaid in which there is no connection to Medicaid payment would not be considered an associated transaction.

We are soliciting comment on all of § 447.207, including comments on the types of transactions that we propose would and would not be considered ''associated transactions'' for the purpose of this section.

13. State Plan Requirements (§ 447.252)

We are proposing to add paragraphs (d) and (e) to § 447.252 regarding state plan requirements for payments for inpatient hospital and long-term care facility services, to implement new approval requirements for state plans and any SPAs proposing to make supplemental payments to providers of these services and to define a transition period for currently authorized supplemental payments to begin to meet the proposed new requirements. In § 447.302, we propose similar requirements for supplemental payments proposed for outpatient hospital services, as described in more detail below. We are proposing to limit approval for any Medicaid supplemental payments to a period of not more than 3 years, and to require states to monitor a supplemental payment program during the term of its approval to ensure that the supplemental payment remains consistent with section 1902(a)(30)(A) of the Act. As discussed in this section and other sections of this preamble, the proposed revisions to §§ 447.252, 447.288(b), and 447.302 include considerable data reporting requirements which would implement section 1902(a)(6) of the Act which provide that the state agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports. We believe the robust payment data we propose to require is necessary to ensure the proper and efficient administration of the plan; to ensure that payments are consistent with efficiency, economy, and quality of care; and otherwise to assist us in appropriately overseeing the Medicaid program.

Specifically, we propose in § 447.252(d) that CMS may approve a supplemental payment, as defined in § 447.286, provided for under the state plan or a SPA for a period not to exceed 3 years. A state whose supplemental payment approval period has expired or is expiring may request a SPA to renew the supplemental payment for a subsequent period not to exceed 3 years, consistent with the requirements of § 447.252. A time-limited supplemental payment allows CMS and the state an opportunity to revisit state plan supplemental payments to ensure that they remain consistent with efficiency, economy, and quality of care, as required under section 1902(a)(30)(A) of the Act. Over the years, CMS and various oversight bodies conducting financial management reviews and audits have identified areas where unchecked supplemental payments have resulted in payments that appeared to be excessive, and CMS had little recourse to take action. Such audits and financial reviews conducted by CMS or other oversight agencies could take years and require a large number of state and federal resources to complete, and ultimately resolve. As noted earlier in this preamble, in 2015, the GAO issued a report entitled, ''Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy,'' in which it concluded that, ''[w]ithout good data on payments to individual providers, a policy and criteria for assessing whether the payments are economical and efficient, and a process for reviewing such payments, the federal government could be paying states hundreds of millions, or billions, more than what is appropriate.'' [9] As a result, the GAO has recommended that, to better ensure the fiscal integrity of the program, we should establish financial reporting at a provider-specific level and clarify permissible methods for calculating Medicaid supplemental payment amounts. Based on this and other oversight entity recommendations, and CMS' experience administering the Medicaid program at the federal level, we believe that the time-limited approval of supplemental payments is necessary for the proper and efficient administration of state Medicaid plans to ensure the continuing consistency of supplemental payments with applicable statutory requirements and generally to ensure appropriate oversight.

We are not proposing to limit the number of times a state may request, and receive approval for renewal of, a supplemental payment program, provided that each request meets all applicable requirements. We propose that a state plan or SPA that would provide for a supplemental payment would be required to include: (1) An explanation of how the state plan or SPA will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including that provision's standards with respect to efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment, for example, with respect to the Medicaid program, providers, and beneficiaries; (2) the criteria to determine which providers are eligible to receive the supplemental payment; (3) a comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including specified content; (4) the duration of the supplemental payment authority (not to exceed 3 years); (5) a monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries; and (6) for a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act. For the state's comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider as required under item (3), we would require the state to provide all of the following: (i) The amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment; (ii) if applicable, the specific criteria with respect to Medicaid

[9] U.S. Gov't Accountability Office, GAO–15–322, Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy, 46 (2015), *https://www.gao.gov/assets/670/669561.pdf.*

service, utilization, or cost data from the proposed state plan rate year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment; (iii) the timing of the supplemental payment to each eligible provider; (iv) an assurance that the total Medicaid payment to an inpatient hospital provider, including the supplemental payment, will not exceed the upper limits specified in § 447.271; and (v) if not already submitted, an UPL demonstration as required by § 447.272 and described in proposed § 447.288.

We already request the information specified in items (1) through (3), above, from states when a state makes a state plan submission that includes a supplemental payment. Currently, we request this information either informally, by seeking assurances from the state in connection with the request for a SPA, or more formally, by requesting changes to the language of the proposed SPA itself. These requirements also are consistent with § 430.10, which requires a state plan to be a comprehensive written statement which serves as the basis for FFP; as such, we are proposing to specify in regulation the essential elements of a comprehensive written methodology for a Medicaid supplemental payment. Consistent with longstanding policy, for a state plan to be comprehensive, it must include the detailed methodologies by which the state makes payments, such that we and the state have the information necessary to determine which providers qualify for a payment, the amount of each provider's payment, and the manner in which payments are distributed to the qualifying providers.

While items (1) through (3), above, would codify our current practice in the regulation, items (4) through (6) would be new requirements. Item (4) would require the state to identify an expiration date, or sunset date, for the supplemental payment, not to exceed a duration of 3 years. A 3-year approval period would also be consistent with our general approach with respect to demonstration projects under section 1115 of the Act, which often are approved for 3-year periods to allow for adequate time for the implementation and testing, supported by ongoing monitoring, and which culminate in an evaluation of the effects of the demonstration. Each time a state submits a SPA to renew a supplemental payment, the state would be able to request a new approval period of up to 3 years. The state could submit a SPA for CMS consideration to renew a supplemental payment at any point during the 3-year approval period, according to the state's chosen timeframe, which the state should determine to allow sufficient time for our review and approval. We considered using a tiered approval time period, such as an initial approval period of up to 5 years followed by renewal periods of up to 3 years, but decided not to propose this policy due to the increased burden that it could cause.

We have found that supplemental payments that are established under the state plan and not reviewed for a long period of time may result in issues of compliance with applicable statutory and regulatory requirements that do not promptly come to our, or the state's, attention. For example, as discussed elsewhere in this preamble, particularly with respect to proposed § 447.288, the issue of fluidity of provider ownership can result in issues involving UPL supplemental payments, and where payments are made improperly, can require extensive federal and state resources to resolve. In the example discussed in connection with proposed § 447.288, the qualifying criteria for providers made all ''non-state government owned or operated'' facilities eligible for supplemental payments up to the UPL for those providers. A few years after this supplemental payment structure was approved, the state was approached by providers who wanted to change their ownership or operational categorization to meet the ''non-state government'' criteria, apparently so that they could qualify for the UPL supplemental payments under the state plan. The state allowed the providers to make the change without prior CMS review or approval, and subsequently began making UPL supplemental payments to the newly recategorized providers. Upon review of the supplemental payment program in question, CMS found that none of the asserted changes in ownership or operations supported the providers' recategorization, and that the providers therefore were ineligible for the UPL supplemental payments the state had been making. In this example, the state was also using funds impermissibly transferred from private entities, which the state characterized as IGTs as a result of the asserted recategorization of the provider as non-state government-owned or operated. To resolve the identified issue, CMS had to undergo a thorough financial management review, which involved numerous CMS staff reviewing financial statements, provider payments, provider records, and interviewing numerous state and provider staff members to determine the provider's eligibility for the payment under the approved state plan. CMS formally issued the financial management review in November 2015 for claims for services provided in state FYs 2010 and 2011, and ultimately issued a disallowance in September 2018. If CMS had the ability routinely to re-review state supplemental payment programs, we would not have approved the expansion of this payment to non-qualifying providers under the plan because the private providers were also funding the non-federal share of a Medicaid payment, which is unallowable under the statute. Because of situations like this and related concerns, we believe it is necessary for the proper and efficient administration of state Medicaid plans to require that supplemental payment programs be submitted for CMS review and approval at least every 3 years, to ensure they are and remain consistent with the efficiency, economy, and quality requirements under section 1902(a)(30)(A) of the Act and the parameters concerning permissible sources of non-federal share under section 1903(w) of the Act.

In our experience, a number of states that seem to effectively use supplemental payments re-submit their supplemental payment programs to CMS on an annual basis, as the pools funded by the supplemental payments are annually re-authorized by the state legislature. Such supplemental payment programs would not be impacted by the proposed 3-year limit. States submitting annual updates to supplemental payment programs, like other states with supplemental payment programs, would however newly be required to comply with the other proposed requirements, including items (5) and (6), discussed above. Proposed § 447.252(d)(5) and (6) concern monitoring and evaluation requirements to assess the effects of the state's supplemental payment program. Specifically, paragraph (d)(5) would require the state to submit a monitoring plan to ensure the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the supplemental payment's effects on the Medicaid program, for example, with respect to providers and beneficiaries. For a SPA proposing to renew a supplemental payment for a subsequent approval period, paragraph (d)(6) would require the state to submit such an evaluation and to include an analysis of the impact of the supplemental payment on the state's compliance with section 1902(a)(30)(A)

of the Act. For example, a state could seek a 3-year approval period for a supplemental payment to increase payments to rural hospitals, with the goal of increasing beneficiary access to services provided by rural hospitals. Over the next 3 years, the state would monitor the effects of the program, to determine whether the supplemental payment is meeting its goals and remains consistent with applicable requirements. At the end of the 3-year period, if the state wished to renew the supplemental payment, it would submit its evaluation and analysis with its renewal request to us, which would inform our determination of whether payments under a renewed supplemental payment program would be consistent with applicable requirements, including those in section 1902(a)(30)(A) of the Act. We anticipate that there may be cases in which the state's evaluation of a supplemental payment program's effectiveness in meeting its stated goals requires more time to evaluate; in such cases, provided we are able to determine that the supplemental payment meets all applicable statutory and regulatory requirements, we would anticipate approving the renewal. Notably, even for a state requesting to renew a supplemental payment program with no changes, we would require the state to submit the evaluation and analysis required under proposed § 447.252(d)(6) as part of our review of the supplemental payment for consistency with applicable statutory and regulatory requirements.

Finally, in considering the 3-year approval period for supplemental payments, we developed a transition plan to provide states with an adequate opportunity to come into compliance with the proposed requirements. To accomplish the policy objectives described above, we believe we must begin to apply the proposed policies to current state plan provisions that authorize supplemental payments that are approved as of the effective date of the final rule. It is no less necessary to ensure the proper and efficient administration of the state plan and ensure that applicable requirements continue to be met, to rigorously evaluate currently existing supplemental payment programs, as it is to do so for new supplemental payment programs that may be approved prospectively. Accordingly, in proposed § 447.252(e), for state plan provisions approved 3 or more years prior to the effective date of the final rule, we propose that the state plan authority would expire 2 calendar years following the effective date of the final rule. For state plan provisions approved less than 3 years prior to the effective date of the final rule, we propose that the state plan authority would expire 3 years following the effective date of the final rule. We believe this is a generous timeline for transitioning to the proposed 3-year time limit for supplemental payments under the state plan. This timeline provides states with currently approved supplemental payment programs with at least 2 years, and as many as 3 years, before a state wishing to continue the supplemental payment program would need to seek renewal or a new approval.

We are soliciting comment on this entire section, including the proposed state plan elements for supplemental payments and the proposed provisions that would place a limited approval timeframe on state's proposed supplemental payments. For the timeframes, we are seeking input on both the length of 3-year approval period and the length of the proposed transition period for currently approved supplemental payments. We considered proposing a 5-year compliance transition period instead of the proposed 3-year compliance transition period in § 447.252(e). This would have extended the amount of time states would have to bring existing, approved supplemental payment methodologies into compliance with the provisions of the proposed rule in §§ 447.252 and 447.302, but determined that the shortened timeframe would be easier to administer as many states already submit annual supplemental payment proposals. We decided to propose a 3-year transition period to account for states where changes may require legislative action as some legislatures meet on a biennial basis and such a timeframe would provide an opportunity for all legilslatures to address existing supplemental payment programs. We are requesting comment on whether or not to pursue this or a lengthier transition and approval/renewal timeline for supplemental payments.

14. Inpatient Services: Application of UPLs (§ 447.272)

To promote improved oversight of Medicaid program FFS expenditures for services subject to the UPL, we are proposing changes to § 447.272. Many of the proposed changes to § 447.272 would formally codify our current policy in regulation text, while others are newly proposed standards. We have long relied upon the UPL requirements in § 447.272, and the related review of total inpatient hospital Medicaid payments in relation to a provider's cost or a reasonable estimate of what Medicare payment amounts would have been, as implementing section 1902(a)(30)(A) of the Act, which requires that states assure that payments are consistent with efficiency, economy, and quality of care. As stated earlier in the preamble, the aggregate application of these UPLs has preserved state flexibility for setting provider-specific payments while creating an overall payment ceiling as a mechanism for determining economy and efficiency of payment for services, consistent with section 1902(a)(30)(A) of the Act.

We are proposing to amend paragraph (a) to revise the current ownership groups (state government-owned or operated, non-state government owned or operated, and privately-owned and operated facilities) used to establish the UPL. We propose to replace these provider designations with ''state government providers,'' ''non-state government providers,'' and ''private providers.'' We propose to codify the substantive definitions of these provider designations in proposed § 447.286. As discussed below, we would define ''state government provider'' to refer to a health care provider as defined in § 433.52, including those defined in § 447.251, that is a unit of state government or state university teaching hospital. In determining whether a provider is a unit of state government, we would consider the totality of the circumstances, including but not limited to specific considerations identified in proposed § 447.286. Similarly, we would define ''non-state government provider'' to refer to a health care provider as defined in § 433.52, including those defined in § 447.251, that is a unit of local government in a state, including a city, county, special purpose district, or other governmental unit in the state that is not the state, which has access to and exercises administrative control over state funds appropriated to it by the legislature and/or local tax revenue, including the ability to expend such appropriated or tax revenue funds. In determining whether a provider is non-state government provider, we would consider the totality of the circumstances, including but not limited to specific considerations identified in proposed § 447.286. We would define a ''private provider'' to mean a health care provider as defined in § 433.52, including those defined in § 447.251, that is not a state government provider or a non-state government provider.

The proposed changes in provider designations would reinforce the

relationship between a provider's designation and its ability (or inability) to provide the source of non-federal share for Medicaid payments. Under the current system of categorization by ownership or operational interests, there can be ambiguity with respect to the appropriate category for a provider when certain responsibilities of ownership or operation are divided between more than one entity. For example, there is currently the possibility that a private nursing facility could transfer the deed to its real property to the county government, but the private entity would continue to administer all functions of the provider as though it were the actual owner, leaving the county government as the owner only in name but not any function. For the provider to make an IGT, the private entity would give funds to the county government, such as through a lease payment for the real property, to be used as the source of the non-federal share of Medicaid payments that the state could then make back to the provider in the form of supplemental payments. This effective self-funding of the non-federal share of the supplemental payments by the provider would not have been possible if the provider were categorized as privately owned and operated, since it would have been unable to make the IGT to support the supplemental payments back to it. In this situation, we view this transferred amount (for example, the lease payment) as an impermissible source of the non-federal share, since the funds used to support the IGT are not obtained from state or local tax revenue and, as discussed elsewhere in this preamble, would constitute a non-bona fide provider-related donation.

Through the state plan review process and our review of UPL demonstrations, we have observed that some states have re-categorized a number of providers from privately-owned or operated facilities to a governmentally owned or operated designation, either state government-owned or operated facilities or non-state government-owned or operated facilities. In some instances, the change in ownership category appears to be only a device to permit the state to make supplemental payments to a provider and demonstrate compliance with the UPL, rather than reflective of an actual change in the provider's true ownership or operational interests, in view of the apparent continuity of the provider's business structure and activities. We believe this shift in designation has facilitated higher supplemental payments to certain providers, without the state incurring additional cost to fund the non-federal share of payment where the private operator passes funds to the new governmental owner and those funds are either used: (1) To make an IGT or (2) supplant funds that are otherwise used to make an IGT to the state in order to make a supplemental payment targeted toward the private entity. We are concerned that this type of arrangement is not consistent with the basic construct of the Medicaid program as a cooperative federal-state partnership where each party shares in the cost of providing medical assistance to beneficiaries.

We propose to amend § 447.272(b) by clarifying that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in 42 CFR, chapter IV, subchapter B; or allowed costs established in accordance with Medicaid cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in part 413. The specific data sources, methodology parameters, and acceptable UPL demonstration methodologies are specified in proposed § 447.288(b).

The existing regulations simply state that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter, pursuant to which we have defined UPLs as a payment limit set at the aggregate amount that Medicare would have paid for the same Medicaid services, using either a Medicare payment methodology or Medicare cost principles. These two methods are employed because these are the two methods that Medicare has historically used to pay for services as authorized in chapter 42, subchapter B. In establishing these UPL methodologies, we have required that states set the UPL using the Medicare equivalent payment or cost amount, then compare the aggregate Medicaid payments for the defined period to the UPL. For purposes of this proposed rule and to be consistent with prior regulatory action, the term ''Medicare equivalent'' means the Medicare equivalent to the Medicaid payment, data, or services. For example, the Medicare equivalent payment means the amount that would be paid for Medicaid services furnished by the group of providers if those services were provided to Medicare beneficiaries and paid under Medicare payment principles. We are proposing to codify our existing policy related to the use of the two methods of demonstrating the Medicaid UPL, by using the Medicare equivalent payment amount or cost amount, and the process for establishing and demonstrating compliance with the UPL in § 477.288(b) of this proposed rule.

We considered proposing to define specific methods by which states would be required to demonstrate compliance with the UPL in each of §§ 447.272 and 447.321, but determined that the proposed § 447.288 would allow us to define necessary data elements, parameters, and methodologies for demonstrating compliance with UPLs in one location, for purposes of both the inpatient and outpatient UPLs under §§ 447.272 and 447.321, respectively. To summarize briefly, proposed § 447.288 describes the data sources, data parameters, and methodologies that must be considered and used in demonstrating compliance with the UPL. It describes the appropriate Medicare data and the creation of ratios using either cost or payment data calculations, the Medicaid charge data to be multiplied by a ratio either of Medicare costs-to-charges or of Medicare payments-to-charges to calculate the UPL amount, any associated considerations (such as inflation adjustments, utilization adjustments, or other cost adjustments), and the Medicaid payment data. For a detailed discussion of these proposed UPL requirements, please refer to the discussion below related to § 447.288.

We invite comment on all proposed new provisions and proposed amendments in this section.

15. Basis and Purpose (§ 447.284)

We are proposing to add subpart D to part 447 to implement sections 1902(a)(6) and (a)(30)(A) of the Act, which require, respectively, that a state plan for medical assistance must provide that the state agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports, and to assure that payments are consistent with efficiency, economy, and quality of care. As discussed in detail above and in subsequent sections below, this information would improve the transparency of Medicaid payments and provide us with more information to understand the basis of Medicaid supplemental payments at the individual provider level in a manner consistent with the recommendations of the oversight bodies as mentioned

elsewhere in this preamble. Moreover, this information would be used in concert with annual UPL demonstrations and state expenditure data to improve our oversight of state expenditures and FFP. Accordingly, we are proposing to require states to submit quarterly and annual reports which detail the total provider payments, including base and supplemental payments, authorized under the state plan and demonstration authority. We are also proposing that the states submit an additional annual report disclosing the amount of provider contributions provided to the state to support the non-federal share of the Medicaid payments along with the total payments received by the contributing providers. The provider contributions include all provider taxes, IGTs, CPEs, and any provider-related donations as described in part 433, subpart B. This new subpart would provide definitions for terms critical to the requirements for supplemental payment programs, including with respect to UPL demonstrations (§ 447.286), establish new data submission requirements for supplemental payments under the state plan (§ 447.288), and specify the consequences that would apply when a state fails to report required information (§ 447.290). We believe these proposed provisions are necessary to ensure the proper and efficient administration of state Medicaid plans with respect to supplemental payment programs, and generally to better enable us to perform our oversight function with respect to the Medicaid program.

We have a long history of establishing data reporting requirements for states. For financial data reports such as the UPL data demonstrations, we have long relied upon the current language in §§ 447.272 and 447.321, which we have discussed in subregulatory guidance in the form of SMDLs, particularly SMDL 13–003, to provide additional information regarding required data and the timeline and manner in which such data is to be reported. We have also defined reporting requirements regarding the Medicaid DSH program through regulations in § 447.299. Since codifying the DSH reporting requirements in regulation, we have found that data reporting by states has become far more consistent, and as a result, we have been able to quickly identify areas where DSH payments have been made inappropriately or when the state has made a payment outside of the state plan methodology, and thus we have been able to more efficiently focus our resources to those problematic areas. We have also been able to work with states to update state plan language so that the distribution methodology for their DSH payments is comprehensively described in the state plan, in accordance with federal requirements. Based in part on this experience with the usefulness of comprehensive data reporting about state payments to providers, we are proposing uniform reporting requirements for additional state Medicaid payments, including supplemental payments made under the UPL. Our expectation is that such reporting would allow CMS to focus our resources to areas where there appear to be issues, either in the payment methodology or the underlying financing, and provide states with technical assistance to the extent that the issues identified may be resolved through strengthening the state plan language so that it accurately and comprehensively describes the state's payment rates and methodologies.

In proposed § 447.284(a), we would specify that proposed new subpart D would set forth additional requirements for supplemental payments made under the state plan, and implement section 1902(a)(6) and (a)(30) of the Act. Section 447.284(b) would provide that the reporting requirements in subpart D are applicable to supplemental payments to which a UPL applies under §§ 447.272 or 447.321.

We are soliciting comments on the statement of basis and purpose as proposed in § 447.284.

16. Definitions (§ 447.286)

We are proposing to add § 447.286 to define the following terms, as they are used in proposed part 447, subpart D: Base payment, Non-state government provider, Private provider, state government provider, and Supplemental payment. Clear definitions of these terms are needed so that states and other stakeholders can have a clear understanding of what is required with respect to the proposed reporting requirements for supplemental payments and UPL demonstrations, and to allow us to clearly track supplemental payments and ensure a consistent reporting and UPL demonstration process.

Specifically, we propose to define the term ''base payment'' to mean a payment, other than a supplemental payment, made to a provider in accordance with the payment methodology authorized in the state plan or is paid to the provider through its participation with a Medicaid MCO entity under the authority in part 438. Base payments are documented at the beneficiary level in MSIS or T–MSIS and include all payments made to a provider for specific Medicaid services rendered to individual Medicaid beneficiaries, including any payment adjustments, add-ons, or other additional payments received by the provider that can be attributed to a particular service provided to the beneficiary, such as payment adjustments made to account for a higher level of care or complexity of services provided to the beneficiary. We believe that, in defining a base payment to a provider, it is appropriate to start with the most fundamental component of the payment that reimburses the provider for furnishing a specific service to a particular beneficiary. In some cases, the base payment may be the only payment the provider receives. We considered not including payment adjustments, which are payments made to providers based on certain provider-specific criteria, add-on payments, and other per service payments apart from the most basic payment, but we determined that it would be more appropriate to include all payments made to a provider for specific Medicaid services rendered to individual Medicaid beneficiaries in the proposed definition. When states pay providers based on patient acuity, complexity of services, characteristics of the provider, or add-on payments, including but not limited to add-on payments for quality of services, such payments can be directly tied to the provision of a service to an individual Medicaid beneficiary and are available to all providers within the Medicaid benefit category. The base payment, including add-on amounts, includes all payment amounts intended to fully reimburse the provider for furnishing a specific service to a particular beneficiary, whereas supplemental payments are made as a lump sum intended to reimburse for Medicaid services generally, rather than particular services furnished to an individual beneficiary. We are soliciting comment on this proposed definition and on the alternative we considered of not including payment adjustments such as incentive payments and other add-on payments that are paid on a per claim basis.

We propose to define non-state government provider to mean a health care provider, as defined in § 433.52, including those defined in § 447.251, that is a unit of local government in a state, including a city, county, special purpose district, or other governmental unit in the state that is not the state, which has access to and exercises administrative control over state-appropriated funds from the legislature

or local tax revenue, including the ability to dispense such funds. We propose to consider the entity's access to and administrative control over state-appropriated funds from the legislature or local tax revenue in this definition to link the provider category to the ability of the provider to supply the non-federal share funds in a manner consistent with section 1903(w)(6)(A) of the Act. We anticipate that questions may arise about whether a provider is a governmental or a private entity, for purposes of this definition. To resolve such questions, we propose that we would consider the totality of the circumstances, including, but not limited to, the identity and character of any entity or entities other than the provider that share responsibilities of ownership or operation of the provider, and including the nature of any relationship among such entities and the relationship between such entity or entities and the provider. In determining whether an entity shares responsibilities of ownership or operation of the provider, our consideration would include, but would not be limited to, whether the entity: (1) Has immediate authority to make decisions regarding the operation of the provider; (2) bears the legal responsibility for risk from losses from operations of the provider; (3) has immediate authority over the disposition of revenue from operations of the provider; (4) has immediate authority with regard to hiring, retention, payment, and dismissal of personnel performing functions related to the operation of the provider; (5) bears legal responsibility for payment of taxes on provider revenues and real property, if any are assessed; or (6) bears the responsibility of paying any medical malpractice premiums or other premiums to insure the real property or other operations, activities, or assets of the provider.

In determining whether a relevant entity (that is, the provider and any entity or entities other than the provider that share responsibilities of ownership or operation of the provider) is a unit of a non-state government, we would consider the character of the entity which would include, but would not be limited to, whether the entity: (1) Is described in its communications to other entities as a unit of non-state government, or otherwise; (2) is characterized as a unit of non-state government by the state solely for the purposes of Medicaid financing and payments, and not for other purposes (for example, taxation); and (3) has access to and exercises administrative control over state funds appropriated to it by the legislature and/or local tax revenue, including the ability to expend such appropriated or tax revenue funds, based on its characterization as a governmental entity.

In recent years, states have proposed a number of SPAs which sought to re-designate the UPL ownership category of a provider and to allow that provider to make an IGT, up to the applicable UPL, to fund the non-federal portion of a new Medicaid supplemental payment. Oftentimes, a hallmark of these proposals has been the sale of some asset of the provider (such as the provider's license or the facility's certification) for some nominal fee, with the private entity (the ''seller'') otherwise retaining critical responsibilities of ownership, and with the IGT, in practical reality, coming from the private entity's funds. This approach is inconsistent with the statute and regulations, particularly sections 1902(a)(30)(A) and 1903(w)(6)(A) of the Act and implementing regulations at §§ 433.51, 447.272 and 447.321.

Based on our experience with such SPAs, it appears that some states have sought to manipulate the characterization of providers' ownership to achieve problematic Medicaid financing arrangements. In arrangements we have observed, the operator essentially functioned as the owner and the operator of the facility. Accordingly, we believe a more effective approach to appropriately categorizing providers for purposes of the UPL would be to consider the totality of the circumstances relevant to the character of the provider, rather than attempting to parse more narrowly whether features of particular entities purported to be the provider's owner and/or operator mean that the provider is properly categorized as a unit of non-state government, which our experience has borne out may be more susceptible to manipulation. We understand that the business models of health care providers and their facilities are layered and complex. However, as discussed above, we are troubled by instances we have observed in which some states have attempted to re-characterize facilities as non-state government owned or operated, where such characterization was not supported by the actual structure and operation of the facility, in an ultimate effort to generate more federal Medicaid revenue without corresponding financial participation from the state. We believe such arrangements violate applicable statutes and regulations, are inconsistent with the fiscal integrity of the Medicaid program, and are generally abusive of the federal-state partnership that Congress has prescribed for the Medicaid program.

We propose to define private provider to mean a health care provider as defined in § 433.52, including those defined in § 447.251, that is not a state government provider or a non-state government provider. This is intended to be a catch-all for remaining health care providers in the state, that are not state government providers or non-state government providers, for purposes of this section. We are soliciting comments on this proposed definition of private provider.

We propose to define state government provider to mean a health care provider, as defined in § 433.52, including those defined in § 447.251, that is a unit of state government or a state university teaching hospital. Similar to the proposed definition of non-state government provider, we propose that, in determining whether a provider is a state government provider, we would consider the totality of the circumstances, including, but not limited to, the identity and character of any entity or entities other than the provider that share responsibilities of ownership or operation of the provider, and including the nature of any relationship among such entities and the relationship between such entity or entities and the provider. The factors that we propose to consider, without limitation, include those discussed above regarding the proposed definition of non-state government provider. And similar to that proposed definition, in determining whether a relevant entity is a state government or state university teaching hospital, we propose that our consideration would include, without limitation, the factors discussed above in connection with the proposed definition of non-state government provider.

Regarding the proposed definitions of non-state government provider, private provider, and state government provider, we understand that health care facilities often enter into business relationships with other entities to perform various functions, including, but not limited to, the care of beneficiaries. We recognize, and do not wish to interfere with, legitimate business relationships between providers and other entities, or among such other entities in relation to the provider. In fact, we believe that the current definitions of non-state government-owned or operated, state government-owned or operated, and privately-owned and operated may have inadvertently distorted such relationships by encouraging new or

different business relationships between providers and other entities, or among such other entities in relation to a provider, with no useful purpose other than to manipulate Medicaid financing in problematic ways. As such, we are proposing to identify a provider as a non-state government provider or state government provider in consideration of the totality of the circumstances, including, but not limited to, the identity and character of any entity or entities other than the provider that share responsibilities of ownership or operation of the provider, and including the nature of any relationship among such entities and the relationship between such entity or entities and the provider. These proposed definitions are intended to work together with the UPL rules and the provisions governing non-federal share financing and provider-related donations to safeguard the fiscal integrity of the Medicaid program.

We propose to define ''supplemental payment'' to mean a Medicaid payment to a provider that is in addition to the base payments to the provider, other than DSH payments under part 447, subpart E, made under state plan authority or demonstration authority. Supplemental payments cannot be attributed to a particular provider claim for specific services provided to an individual recipient and are often made to the provider in a lump sum on a monthly, quarterly, or annual basis apart from payments for a provider claim, and therefore, cannot be directly linked to a provider claim for specific services provided to an individual Medicaid beneficiary. In short, supplemental payments are any payments to a provider other than Base payments or DSH payments under part 447, subpart E. Supplemental payments are lump sum payments made to the provider at various intervals depending on the state program, including supplemental payments made through section 1115 demonstrations such as uncompensated care pools and delivery system reform incentive payments (DSRIP). We are not making determinations about those particular intervals at which payments are distributed to providers other than to require that states specify such information as proposed in § 447.252(d) of this proposed rule. We have historically considered DSH payments under part 447, subpart E as being distinct payments authorized separately in the statute in section 1923 of the Act which are separate from Medicaid supplemental payments. The DSH payments serve the specific purpose of taking into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs, including Medicaid beneficiaries and the uninsured. Serving these patients may cause hospitals to incur higher costs, including significant uncompensated care costs for serving low income populations. Supplemental payments and DSH payments are paid under separate authorities in the Act. Supplemental payments are authorized in section 1902(a)(30)(A) of the Act, which requires that the state plan provide methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care and DSH payments are authorized in section 1923 of the Act. Therefore, supplemental payments and DSH payments are not required to be tied to the same statutory purpose.

We are requesting comment on the revisions to § 447.272, including each of the revised provider category definitions included in this section.

17. Reporting Requirements for UPL Demonstrations and Supplemental Payments (§ 447.288)

We are proposing to add § 447.288 to define documentation requirements for UPL demonstrations and for states that make supplemental payments. As noted several times elsewhere in this preamble, the GAO has frequently cited the lack of adequate Medicaid provider payment data as a deficiency that compromises CMS oversight and recommended we take concrete steps to ensure the timely submission of accurate state payment data. In 2015, one GAO report concluded that ''[w]ithout good data on payments to individual providers, a policy and criteria for assessing whether the payments are economical and efficient, and a process for reviewing such payments, the federal government could be paying states hundreds of millions, or billions, more than what is appropriate'' (U.S. Gov't Accountability Office, GAO–15–322, Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy, 46 (2015)). Accordingly, this proposals represents an effort to address the concerns raised by GAO and to create a more robust audit trail for state payments to providers to allow for better CMS oversight. We believe that this proposed provision is necessary to ensure the proper and efficient operation of the Medicaid state plan, in a manner that complies with the requirements of sections 1902(a)(4), (a)(6) and (a)(30)(A) of the Act. In new § 447.288(a), we propose that, beginning October 1, of the first year following the year in which the final rule may take effect, and annually thereafter, by October 1 of each year, in accordance with the requirements of § 447.288 and in the manner and format specified by the Secretary, each state would be required to submit a demonstration of compliance with the applicable UPL for each of the following services for which the state makes payment: Inpatient hospital, as specified in § 447.272; outpatient hospital, as specified in § 447.321; nursing facility, as specified in § 447.272; ICF/IID, as specified in § 447.272; and institution for mental diseases (IMD), as specified in § 447.272. The submission of UPLs for these facilities and services is consistent with existing CMS regulations in §§ 447.272 and 447.321, as well as CMS guidance document SMDL #13–003. Under these regulations and policy guidance, states are already providing UPL demonstrations for the above referenced services to demonstrate that payments are consistent with economy, efficiency, and quality of care as required in section 1902(a)(30)(A) of the Act. These demonstrations are submitted annually, or any time a state submits a SPA that proposes to amend the payment rate or methodology for one of the aforementioned facilities or service categories. Of note, as discussed in greater detail below, we are proposing to remove the psychiatric residential treatment facilities (PRTF) and clinic UPLs, which would not be included in the annual reporting requirements.

We are proposing to add § 447.288(b) to define UPL demonstration standards. When demonstrating the UPL, states would be required to use the data sources and adhere to the data standards, and acceptable UPL methodologies specified in this section. We believe that these proposed requirements would assist CMS and states in determining the Medicaid inpatient and outpatient facility payment rates are consistent with economy, efficiency and quality of care under section 1902(a)(30)(A) of the Act.

Over time, we have received numerous requests for feedback on the use of specific data elements and on acceptable UPL methodologies. We are hopeful these proposed provisions, which, except as noted below, would codify current policy, would enhance states' understanding of acceptable UPL demonstration standards, as well as improve the quality of UPL submissions.

We are proposing no longer to require states to submit UPL demonstrations for PRTFs and clinics. PRTFs are facilities subject to the payment limits defined in

§ 447.325, which states that the state Medicaid agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances. The reason for this proposed change is two-fold. First, the payment limit in § 447.325 limits the state's payment to a provider to the provider's customary charges or, if less, the prevailing charges in the locality for comparable services under comparable circumstances. Providers determine what they will charge for items and services furnished. To pay a provider's charge under the state plan, a state plan could simply provide that its payments will not exceed the provider's customary charge, provided the state plan also describes a comprehensive methodology for ensuring that payments do not exceed the prevailing charges in the locality for comparable services under comparable circumstances. Second, in our experience, states do not make supplemental payments to these facilities, and such provider's base payments are generally equal to the provider's charge. As such, the UPL is less of a calculation, as with other inpatient-type services, and more of a confirmation the state pays no more than the provider's charge under the state plan, which can be accomplished through a review of the state plan. We will continue to review compliance with the § 447.325 through a review of the SPA submissions as has been our historical practice. The removal of the clinic UPL is discussed in more detail below under § 447.321 of this preamble.

In proposed § 447.288(b), we propose to specify detailed UPL demonstration standards for demonstrating that Medicaid FFS payments are made in aggregate amounts that are less than or equal to the aggregate cost or Medicare payment amounts. The purpose of the proposed provisions is to ensure uniform reporting of UPL data and a full picture of Medicaid payments within each provider category for each category of services subject to a UPL in a given year. The proposed provisions are intended to specify that states may not pick-and-choose the most beneficial data for each provider within a provider category, but instead to select a UPL methodology and apply a single methodology to all providers within a UPL provider category and service type.

In proposed paragraph (b)(1), we propose defining the data sources for the UPL calculations, which is the Medicare-equivalent cost and charge data and Medicare-equivalent payment and charge data for purposes of the UPL as our primary data sources for the UPL. As noted elsewhere in this proposed rule, the term ''Medicare equivalent'' means the Medicare equivalent to the Medicaid data, payment, or services. Therefore, the term Medicare equivalent payment means the amount that would be paid for Medicaid services furnished by the group of providers if those services were provided to Medicare beneficiaries and paid under Medicare payment principles. Likewise, a reference to Medicare equivalent charges in reference to a UPL calculation means the Medicare charges for the same Medicaid services subject to the UPL.

In proposed paragraph (b)(1)(i), we would require that cost and charge data for all providers must be from either Medicare cost reports, or state-developed cost reports using either Medicare cost reporting principles specified in part 413 or the cost allocation requirements specified in 45 CFR part 75, which implements requirements in 2 CFR part 200, as specified in 2 CFR 200.106. Cost and charge data must: Include only data with dates of service that are no more than 2 years prior to the dates of service covered by the UPL demonstration; and represent costs and charges specifically related to the service subject to the UPL demonstration. As such, each UPL must use costs and charges related to the relevant category of Medicaid services listed in paragraph (a) of § 447.288; and include either Medicare costs and Medicare charges, or total provider costs and total charges, in order to develop a cost-to-charge ratio as described in paragraph (b)(3)(i). The selection must be consistently applied for all providers within the provider category subject to the UPL so that all costs and charges for all providers within a provider category are uniform in the UPL demonstration to ensure uniformity in reporting as discussed above. These requirements are consistent with historical practices related to the collection of information for UPLs and were part of the CMS UPL templates submitted to OMB for approval under control number 0938–1148 (CMS–10398 #13 and #24).

At paragraph (b)(1)(ii), we propose to define Medicare payment demonstrations as using Medicare payment and charge data for all providers from either Medicare cost reports, Medicare payment systems for the specific provider type specified in title 42, chapter IV, subchapter B of the CFR, as applicable, or imputed per diem rates based on Medicare provider payments. ''Imputed'' per diem rates, as discussed in more detail in paragraph (b)(3)(ii)(C), are payments that are calculated by dividing total Medicare payments by Medicare days from the provider census data to calculate an estimated Medicare price per day. The state then is able to multiply this Medicare price per day for each provider by the provider's Medicaid days (also from the provider census), and then sum these products within a service class and provider category to calculate a Medicaid UPL.

The proposed provision goes on to specify that when using Medicare payment and charge data, the data must: Include only data with dates of service that are no more than 2 years prior to the dates of service covered by the UPL demonstration; include only Medicare payments and charges, or Medicare payment and the provider's Medicare census data, specifically related to the service subject to the UPL demonstration; and use either gross Medicare payments and Medicare charges, which includes deductibles and co-insurance but excludes reimbursable bad debt from the Medicare payment, or net Medicare payments and Medicare charges, which excludes deductibles and coinsurance and includes reimbursable bad debt, as reported on a Medicare cost report. The selection of gross or net Medicare payment must be consistent within the ratio for each provider category subject to the UPL. These requirements are consistent with historical practices related to the collection of information for UPLs and were part of the CMS UPL templates submitted to OMB for approval under control number 0938–1148 (CMS–10398 #13 and #24).

For the Medicare payment systems for the specific provider type, we are referring to the prospective payment systems (PPS) in effect for the Medicare program such as the inpatient prospective payment system (IPPS), outpatient prospective payment system (OPPS), skilled nursing facility (SNF) PPS, and any future applicable Medicare PPSs such as the patient driven payment model (PDPM) for SNFs. The requirement that the payment data use data with dates of service that are no more than 2 years prior to the dates of service covered by the UPL demonstration would allow states to use Medicare payment data from a prior period to demonstrate the UPL, particularly in years where Medicare is transitioning to a new payment system. Because states have the flexibility to use data that is no more than 2 years old, states using Medicare payment-based demonstrations would not be required to immediately switch over to using data from a newly implemented Medicare payment system, such as PDPM, to demonstrate

compliance with the UPL if the state is not in a position to do so, but would be able to transition to using that system over a 2-year period. There is no requirement in statute or regulations that mandates states use specific Medicare payment systems in Medicaid for provider payments. Since the UPL is an estimate of the amount that Medicare would have paid for the service, we have always offered states some flexibility to determine UPLs using recent data that is no more than 2 years old, which, in years where Medicare has transitioned to a new payment system, means that states could use data from the prior payment system for up to 2 years after the Medicare transition for purposes of the Medicaid UPL compliance demonstration.

In paragraph (b)(1)(iii), we propose to require that the Medicaid charge data used in calculating the UPL must be derived from the state's Medicaid billing system for services provided during the same dates of service as the Medicare cost or Medicare payment data, as defined above. The Medicare cost and charge or payment and charge data, as applicable, is used to create a ratio with the Medicare cost or payment being the numerator and the Medicare charges are the denominator. Once that ratio is created, the Medicaid charges are multiplied by that ratio. This is discussed in more detail below, but the requirement that the time period of the Medicaid charge data be from the same time period of the Medicare-equivalent data, as defined above, is due to the fact that providers determine what they will charge for items and services furnished to patients, which may change from time to time. If the charges are the same for all payers, then a reasonable estimate of the amount that Medicare would pay for the service would require the use of the Medicaid charge data from the same time period as the Medicare data to calculate the UPL. As discussed in connection with paragraph (b)(3)(i), we propose that a cost-based methodology could only be used for services where a provider applies uniform charges to all payers.

At paragraph (b)(1)(iv), we propose to require Medicaid payment data from a state's Medicaid billing system for services provided during the same dates of service as the Medicare cost or Medicare payment data, as specified in paragraph (b)(1)(i) or (ii) of this section, as applicable, or from the most recent state plan rate year for which a full 12 months of data are available. As with the data requirements in paragraphs (b)(1)(i) and (ii), Medicaid payment data must: Include only data with dates of service that are no more than 2 years prior to the dates of service covered by the UPL; include all actual payments, as well as all projected base and supplemental payments, excluding any payments made for services for which Medicaid is not the primary payer, expected to be made during the time period covered by the UPL demonstration to the providers within the provider category, as applicable; and only be trended by an amount equal to the changes in the Medicaid state plan payment for the applicable service. Using either the most recent Medicaid payment data for the time period subject to the UPL or the payment data from the same time period as the Medicaid charge data (meaning also from the same time period as the Medicare data) is up to the state. Under all circumstances, the Medicaid payment data must include all payments made to the providers, including any proposed payments or projected payments that have not yet been made. This way, the UPL will reflect an accurate depiction of the state's Medicaid payments during the period of the UPL demonstration.

In paragraph (b)(2), we propose to require states to apply certain UPL methodology parameters in calculating the UPL. Specifically, the proposed UPL methodology parameters include the following considerations. First, projected changes in utilization must be accounted for and reflected in the demonstration. If no service-specific utilization projections are available, then projections for enrollment must reflect programmatic changes such as reasonable utilization changes due to managed care enrollment projections. For example, a state may be aware that in the upcoming state-fiscal year, there will be a shift to increase beneficiary enrollment in managed care plans. Projected utilization changes to account for such large programmatic shifts may be used instead of individually determined, service-specific utilization changes, such as inpatient hospital utilization, which may result in a percentage increase or decrease in expected utilization for the relevant services undergoing a shift to managed care. Medicare data may also be projected using Medicare trend factors appropriate to the service and demonstration methodology, which are Medicare payment- or cost-based, with such trend factors being uniformly applied to all providers within a provider category. In this way, states can anticipate and project program changes or changes in expected costs or payments in the UPL that may either increase or decrease the UPL or expected Medicaid payments. For example, an appropriate trend factor with respect to inpatient hospital services, outpatient hospital services, and SNFservices could be the CMS Market Basket rate. This proposed change, which represents a departure from current policy, is proposed in paragraph (b)(2)(ii), which would require uniform application of the trending factor within the provider category. Prior to this proposed rule, we had not formally articulated an expectation of uniform trending of data within a provider category and had accepted UPL demonstrations that did not apply trend factors in a uniform manner. CMS could not determine whether the applied inflation adjustments in those UPLs were always appropriate based on our review. This proposed provision is intended to establish the requirements in regulation for uniform inflation adjustments to the UPLs.

Additionally, we propose that when calculating the aggregate UPL using a cost-based demonstration as described in paragraph (b)(3)(i), the state may include the cost of provider assessments (such as health care-related taxes) paid by each provider in the provider category that is reasonably allocated to Medicaid as an adjustment to the UPL, to the extent that such costs were not already included in the cost-based UPL. For example, many states calculate their provider taxes on inpatient services as a per day payment amount or a per discharge payment amount. The state would calculate the portion of such a tax allocable to Medicaid by multiplying the per day or per discharge tax amount by Medicaid days or Medicaid discharges, as applicable, and include the product of that amount in the UPL for each provider in the provider category. When calculating the aggregate UPL using a cost-based demonstration, states may include the Medicaid-allocated cost of health care related taxes as an adjustment to the UPL amount on a per provider basis. The Medicare cost report does not require states to account for expenses related to health care related taxes as an allowable cost, as this reporting is optional. In the Medicaid program, such expenditures may be included as an allowable cost provided that the portion of the cost allocated to Medicaid can be isolated from the aggregate health care related tax payment.

For example, if a provider has 100 total bed days of which 85 were Medicaid bed days and the provider paid $100 in health care related taxes, the provider could account for $85 of the total tax payment. Our current policy permits states to include the cost

of Medicaid's portion of health care related taxes as an allowed cost for cost based demonstrations, but not payment based demonstrations; we are proposing to codify that existing policy in regulation because, historically, the Medicaid taxes have not been specifically included in the Medicare cost report calculations. The Medicare 2552 (Hospital Cost Report) now includes an option to include provider taxes paid under the authority in section 1903(w) of the Act. To the extent that such taxes are not included in the cost calculation in the Medicare cost report, those costs should be included in the UPL. If the provider taxes are included in the Medicare cost report, the state should not add these costs back into the UPL calculation, which would result in double-counting the tax payments. Our goal in allowing Medicaid provider tax costs to be added back into the cost-based UPL calculations is to ensure that allowable costs incurred by the providers when furnishing services to Medicaid beneficiaries are applied to the UPL calculations to the extent that they were not already captured in the Medicare cost report data, but we do not want such costs to be duplicated through the UPL and the Medicare cost report. This provision only applies to cost-based UPL demonstrations because cost-based demonstration are reflections of the provider's expenses related to the provision of medical services and such amounts may vary based upon factors including health care related-taxes in the state or other relevant jurisdiction, while payment-based UPL demonstrations reflect only the Medicare payment for services under the specific Medicare payment system, and therefore, only adjustments which affect the overall payment under the Medicare payment system can be factored into the UPL demonstration.

Finally, we propose codifying the current policy that the Medicaid payments, in paragraph (b)(1)(iv), included in the UPL calculation must only include payments made for Medicaid services under the specific Medicaid service type at issue in the UPL. For example, the state must not include payments for services other than inpatient hospital services in the inpatient hospital UPL calculation.

In paragraph (b)(3), we propose acceptable methods of demonstrating the UPL. First, we propose that to make a cost-based demonstration in compliance with an applicable UPL, Medicaid covered charges are multiplied by a cost-to-charge ratio developed for the period covered by the UPL demonstration. The state may use a ratio of Medicare costs to Medicare charges, or total provider costs to total provider charges in developing the cost-to-charge ratio, but the selection must be applied consistently to each provider within a provider type, which references the listing of provider types in paragraph (a) of the section. The product of Medicaid covered charges and the cost-to-charge ratio for each provider is summed to determine the aggregate UPL. The demonstration must show that Medicaid payments will not exceed this aggregate UPL for the demonstration period. As explained in more detail below, this methodology may only be used for services where a provider applies uniform charges to all payers. Reported cost must be appropriately allocated between payers so that only costs properly allocated to Medicaid services are included in the demonstration.

In paragraph (b)(3)(i)(A), we propose that states may make a retrospective, cost-based demonstration showing that aggregate Medicaid payments paid to the providers within the provider category during the prior state plan rate year did not exceed the costs incurred by the providers furnishing Medicaid services within the prior state plan rate year period. The term ''retrospective'' simply refers to Medicaid payments that have already been paid for the prior state plan rate year that has already ended, and for which the state does not anticate making any new Medicaid payments. Most often these demonstrations come from states where providers are paid using a reconciled cost methodology under the approved Medicaid state plan, in which case the Medicaid provider payments would be equal to those providers' cost of Medicaid services, and the UPL would demonstrate that payments to providers did not exceed their costs.

In paragraph (b)(3)(i)(B), we propose that states may make a prospective, cost-based demonstration showing that prospective Medicaid payments would not exceed the estimated, prospective cost of furnishing the services for the upcoming state plan rate year period. As explained in more detail below, this methodology may only be used for services where a provider applies uniform charges to all payers. The prospective cost demonstration is a common UPL methodology reviewed by CMS and is often used by states to demonstrate that proposed or projected Medicaid payments are less than a provider cost trended forward from a prior period.

In addition to these cost-based demonstrations, we also propose that states could use payment-based demonstrations to show compliance with an applicable UPL, including retrospective and prospective methodologies and including flexibility for the state to determine an imputed Medicare payment rate to apply in either a retrospective or prospective payment-based demonstration. We propose that the payment-based demonstration data sources would be those identified in paragraphs (b)(1)(ii), (iii), and (iv), and the data standards defined in paragraph (b)(2) would apply. States could make a retrospective payment-to-charge UPL demonstration, where Medicaid covered charges are multiplied by a ratio of Medicare payments to Medicare charges developed for the period covered by the UPL demonstration. The product of Medicaid covered charges and the Medicare payment-to-charge ratio for each provider would be summed to determine the aggregate UPL, and the demonstration must show that Medicaid payments did not exceed this aggregate UPL. Alternatively, we propose that states could make a prospective payment-to-charge UPL demonstration, where Medicaid covered charges are multiplied by a ratio of Medicare payments to Medicare charges developed for the period covered by the UPL demonstration. The product of Medicaid covered charges and the Medicare payment-to-charge ratio for each provider would be summed to determine the aggregate UPL. The demonstration must show that proposed Medicaid payments would not exceed this aggregate UPL within the next state plan rate year immediately following the demonstration period. Regardless of whether a state is using a retrospective or prospecftive payment-to-charge demonstration methodology, we propose that states could use an imputed Medicare per diem payment rate determined by dividing total Medicare prospective payments paid to the provider by the provider's total Medicare patient days, which are derived from the provider's Medicare census data. Each provider's imputed Medicare per diem payment rate would be multiplied by the total number of Medicaid patient days for the provider for the period. The products of this operation for each provider are summed to determine the aggregate UPL. The demonstration must show that Medicaid payments are not in excess of the aggregate UPL, calculated on either a retrospective or prospective basis, consistent with the applicable proposed methodology. This imputed Medicare payment rate methodology is commonly used by long-term care facilities in Medicaid, such as SNFs and IMDs, or in

states whose Medicaid payments are based upon existing Medicare payment systems. For example, a state which uses the Medicare SNF PPS to demonstrate a SNF UPL would divide total Medicare payments by total Medicare SNF bed days. That product, per facility, would be multiplied by the Medicaid bed days, the aggregate of which would be the aggregate UPL. The Medicaid payments for the same time period must not exceed the aggregate UPL.

It is important to note that any UPL methodology that requires the use of a provider's charges to calculate the UPL may only be used to the extent that the provider applies uniform charges to all payers. This is because when developing a cost to charge ratio or a payment to charge ratio, the initial ratio is multiplied by Medicaid charges to determine the UPL amount. ''Charges'' are the amount a hospital or provider bills for medical services, and should be the same for all patients regardless of payer. If the charges used in the cost to charge or Medicare payment to charge ratio are not the same as the Medicaid charges, the calculation of the UPL would be either over- or under-stated. We intend the UPL demonstrations to accurately depict the Medicare cost, or what Medicare would have paid, for the same services, and that is diminished when the underlying data is not accurate.

In new § 447.288(c)(1), we propose that, at the time the state submits its quarterly CMS–64 under § 430.30(c), the state would be required to report certain information for each supplemental payment included on the CMS–64. The proposed reporting elements would not be reported on the CMS–64 itself, but would accompany that submission on a separate, supplemental report. We propose to require states to report information sufficient to identify which providers receive which supplemental payments under the state plan and any demonstration authority, and to enable us to ensure that such payments to the providers are consistent with economy, efficiency, and quality of care, as required under section 1902(a)(30)(A) of the Act. These data submission requirements would include provider-level data on base and supplemental payments made under state plan and demonstration authority by service type. This data would also be required to include the following: The SPA transaction number or demonstration authority number which authorizes the supplemental payment; a listing of each provider that received a supplemental payment under state plan and/or demonstration authority, and, for each: The provider's legal name; the primary physical address of the location or facility where services are provided, including street address, city, state, and ZIP code; the National Provider Identifier (NPI); the Medicaid identification number; the employer identification number (EIN); the service type for which the reported payment was made; the provider specialty type (if applicable, for example, critical access hospital (CAH), pediatric hospital, or teaching hospital); the provider category (that is, state government provider, non-state government provider, or private provider); and the specific amount of the supplemental payment paid to each provider, including the total supplemental payment made to the provider authorized under the specified state plan and the total Medicaid supplemental payment made to the provider under the specified demonstration authority, as applicable.

The specific data elements described above are intended to identify the individual providers receiving payments, the authority for the payments, and the sum of all payments received by the individual providers. Information such as the provider's legal name, primary physical location or facility location where services were provided, NPI, Medicaid identification number, and EIN are needed to identify the specific provider accurately. When the regulation refers to the ''legal'' name, it means the business name of the facility which appears on the provider's license and other legal documentation authorizing the health care operations of the provider. The NPI is required for providers, and EINs are assigned to all businesses by the Internal Revenue Service, and must be on all Health Insurance Portability and Accountability Act (HIPAA) electronic transactions. An NPI is a unique 10-digit number used to identify health care providers. The Medicaid identification number is assigned by the state and is a unique identifier for providers participating in the Medicaid program.

In addition to the provider-identifying information, proposed § 447.288(c)(1) would require the state to report the service type, provider specialty type, and provider category. These data elements are intended to be linked to the payment methodology in the state plan. This information follows how states must describe supplemental payments in the state plan, which is, first, organized by service type, then by provider-specific information, such as specialty type and provider category. If a state establishes a specific methodology or proposes to make a supplemental payment to a specific ''type'' of hospital using specified criteria, such as a non-state government teaching hospital or CAH, such information must appear in the state plan. As the proposed data elements are aligned with how analogous information is recorded in the state plan, we anticipate that this information will help us ensure that supplemental payments are being made to providers in accordance with the qualifying criteria as established in the state plan. Finally, we propose to require the state to report the specific amount of the supplemental payment made to the provider, including the total supplemental payment amount authorized under the specified state plan, as applicable, and the total supplemental payment amount authorized under the demonstration authority, as applicable.

In § 447.288(c)(2), we propose that not later than 60 days after the end of the state fiscal year, each state must annually report aggregate expenditure data for all data elements included in § 447.288(c)(1) plus the following: The state reporting period (state fiscal year start and end dates); the specific amount of Medicaid payments made to each provider, including, as applicable: The total FFS base payments made to the provider authorized under the state plan, the total Medicaid payments made to the provider under demonstration authority, the total amount received from Medicaid beneficiary cost-sharing requirements, donations, and any other funds received from third parties to support the provision of Medicaid services, the total supplemental payment made to the provider authorized under the specified state plan, the total Medicaid supplemental payment made to the provider under the specified demonstration authority, and an aggregate total of Medicaid payments listed above made to the provider.

Section 447.288(c)(2)(iii) would also require the aggregate reporting of the total DSH payments made to the provider, and the Medicaid units of care furnished by the provider (for example, on a provider-specific basis, total Medicaid discharges, days of care, or any other unit of measurement as specified by the Secretary). This proposed data collection effort is designed to allow us to conduct efficient oversight of all payments made to providers on an annual aggregate basis. The data, as reported, would be used to conduct quarterly and annual reviews of state payments as related to payments reported under UPL demonstrations and under the Medicaid state plan.

In § 447.288(c)(3), we propose that, not later than 60 days after the end of the state fiscal year, each state must annually report aggregate and provider-level information on each provider contributing to the state or any unit of local government any funds that are used as a source of non-federal share for any Medicaid supplemental payment. This proposed data submission requirement would include all of the data elements listed in § 447.288(c)(1) and (2), but would also require information related to financial contributions to the state Medicaid program, specifically including: The total of each health care-related tax collected from the provider by any state authority or unit of local government; the total of any costs certified as a CPE by the provider; the total amount contributed by the provider to the state or a unit of local government in the form of an IGT; the total of provider-related donations made by the provider or entity related to a health care provider, as defined in § 433.52, including in-cash and in-kind donations, to the state or a unit of local government, including state university teaching hospitals; and the total funds contributed by the provider (that is, health care-related taxes, CPEs, IGTs, provider-related donations, and any other funds contributed to the state as the non-federal share of a Medicaid payment). When a provider-related entity is related to more than one entity, the state should report the total amount of the related entity's donation for each associated provider. These proposed data elements are intended to be itemized based on all the various payments to a provider and contributions from the provider, as applicable. For example, if a provider receives base and multiple supplemental payments under various SPA authorities and makes a provider tax contribution and an IGT as a means of funding the non-federal share, the state must list each payment and each provider contribution among the proposed required data reporting elements. If there is more than one payment or more than one type of provider contribution (for example, more than one tax or more than one IGT), the state would be required to itemize each payment and each contribution, as applicable. The purpose of such information from states is to determine the totality of provider payments under the Medicaid program and the extent of provider contributions to the non-federal share of such Medicaid payments under the approved state plan.

We are seeking comment on all aspects of the proposals in this section. We are soliciting comment on the proposed reporting requirements in § 447.288(c), including the specific proposed data elements in § 447.288(c)(1) through (3). In particular, we invite comment on whether any of the proposed data elements are duplicative, and on ways we might be able to obtain this necessary information in a manner that appropriately balances administrative burden on states and on us while generating the most accurate data possible.

18. Failure To Report Required Information (§ 447.290)

To effectively ensure that states comply with applicable federal statutory and regulatory requirements, we must have adequate enforcement mechanisms in place. The remedy for issues related to state compliance with regulations is often the withholding of federal funds to compel compliance with applicable federal requirements. We are proposing to add § 447.290 to specify an appropriate avenue of enforcement in the event that a state does not comply with the proposed data reporting requirements in § 447.288. As discussed above, we believe the proposed information reporting requirement under § 447.288 is necessary for the proper and efficient administration of the state Medicaid plan, especially with respect to the plan's compliance with section 1902(a)(30)(A) of the Act, and would be properly required under section 1902(a)(6) of the Act. Therefore, in proposed § 447.290(a), we propose that the state must maintain the underlying information supporting base and supplemental payments, including the information required to be reported under proposed § 447.288, consistent with the requirements of § 433.32, and must provide such information for federal review upon request to facilitate program reviews or OIG audits conducted under §§ 430.32 and 430.33. In proposed § 447.290(b), we propose that if a state fails to timely, completely and accurately report information required under § 447.288 of this chapter, we may reduce future grant awards through deferral in accordance with § 430.40, by the amount of FFP we estimate is attributable to payments made to the provider or providers as to which the state has not reported properly, until such time as the state complies with the reporting requirements. We propose that we may defer FFP if a state submits the required report but the report fails to comply with applicable requirements. Otherwise allowable FFP for expenditures deferred in accordance with this proposed section would be released when we determine that the state has complied with all reporting requirements under proposed § 447.288. The enforcement mechanism proposed in § 447.290 is similar in structure to the mechanism that applies with respect to the DSH reporting requirements, in § 447.299(e). We are soliciting comments on the enforcement mechanism proposed in § 447.290.

19. Limitations on Aggregate Payments for DSHs Beginning October 1, 1992 (§ 447.297)

Current regulations require CMS to publish the annual DSH allotments in a **Federal Register**. This process is not only administratively burdensome, but is unnecessary as we routinely notify states directly regarding annual allotment amounts and make such information publicly available. Therefore, we are proposing to eliminate the § 447.297(c) requirement to publish annual DSH allotments in a **Federal Register** notice and to provide that the Secretary will post preliminary and final national expenditure targets and state DSH allotments in the MBES and at *Medicaid.gov* (or similar successor system or website). Additionally, we are proposing to remove the date in which final national target and allotments are published from April 1st to as soon as practicable. We are also proposing to remove § 447.297(e), which consists of redundant publication requirements already identified in § 447.297(b), (c), and (d), in its entirety to align with our proposed changes § 447.297(c). We are soliciting comments related to these proposed changes.

20. Reporting Requirements (§ 447.299)

To improve the accuracy of identification of provider overpayments discovered through the DSH audit process, we are proposing in § 447.299 to add an additional reporting requirement for annual DSH audit reporting required by § 447.299 and to provide clarifying guidance on the reporting of overpayments identified by the annual DSH audits required under part 455 subpart D. We are proposing to redesignate § 447.299(c)(21) as paragraph (c)(22) of that section, and to add a proposed new § 447.299(c)(21) to require an additional data element for the required annual DSH audit reporting. This new data element would require auditors to quantify the financial impact of any finding which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit. If it is not practicable to determine the actual

financial impact amount, we propose to require a statement of the estimated financial impact for each audit finding identified in the independent certified audit that is not reflected in the data elements identified in § 447.299(c)(6) through (15). For purposes of this paragraph, audit finding means an issue identified in the independent certified audit required under § 455.304 concerning the methodology for computing the hospital specific DSH limit and/or the DSH payments made to the hospital, including, but not limited to, compliance with the hospital-specific DSH limit as defined in § 447.299(c)(16). Audit findings may be related to missing or improper data, lack of documentation, non-compliance with federal statutes and/or regulations, or other deficiencies identified in the independent certified audit. Actual financial impact means the total amount associated with audit findings calculated using the documentation sources identified in § 455.304(c) of this chapter. Estimated financial impact means the total amount associated with audit findings calculated on the basis of the most reliable available information to quantify the amount of an audit finding in circumstances where complete and accurate information necessary to determine the actual financial impact is not available from the documentation sources identified in § 455.304(c) of this chapter. We understand that due to the complexity of issues that may arise, the actual financial impact may not always be calculable; therefore, we propose that, in the expectedly rare event that the actual financial impact cannot be calculated, an estimated financial impact would be required. The estimated financial impact would use the most reliable available information (for example, related source documentation such as data from state systems, hospitals' audited financial statements, and Medicare cost reports) to quantify an audit finding. We believe this additional data reporting element is necessary to better enable our oversight of the Medicaid DSH program to better ensure compliance with the hospital specific DSH limit in section 1923(g) of the Act. Moreover, we believe this requirement would limit the burden on both states and CMS of performing follow-up reviews or audits and will help ensure appropriate recovery and redistribution, as applicable, of all DSH overpayments.

The addition of § 447.299(f) would clarify reporting requirements of DSH overpayments identified in the audit process in accordance with part 433 subpart F, including specifying that states must return DSH payments in excess of hospital-specific cost limits to the federal government identified through annual DSH audits through quarterly reporting on the Form CMS–64 as a decreasing adjustment, or redistributed by the state to other qualifying hospitals, if redistribution is provided for under the approved state plan. Section 447.299(g) would require states to report overpayment redistribution amounts corresponding with the fiscal year DSH allotment, as applicable and consistent with other federal requirements, on the Form CMS–64 within 2 years from the date of discovery and report such redistributions through quarterly reporting on the Form CMS–64 as an increasing adjustment. We solicit comments on the proposed rule.

21. State Plan Requirements (§ 447.302)

We are proposing to revise § 447.302 by adding proposed new paragraphs (a) through (d), which would establish state plan requirements for payments for outpatient hospital services, to implement new approval requirements for state plans and any SPAs proposing to make supplemental payments to providers of these services and to define a transition period for currently authorized supplemental payments to begin to meet the proposed new requirements. These proposals are similar to those we are making in § 447.252(d) with respect to supplemental payments for inpatient hospital, nursing facility, and ICF/IID services. We are proposing to limit approval for state plan supplemental payments for outpatient hospital services to a period of not more than 3 years, and to require states to monitor a supplemental payment program during the term of its approval to ensure that the supplemental payment remains consistent with section 1902(a)(30)(A) of the Act. As discussed in this section and other sections of this preamble, the proposed revisions to §§ 447.252, 447.288(b) and 447.302 include considerable data reporting requirements which would implement section 1902(a)(6) of the Act, requiring the state agency to make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports. The submission of more robust payment data would assist us in providing proper oversight of the Medicaid program in determining that state Medicaid payments are made in a manner consistent with federal statute and regulations, including section 1902(a)(30)(A) of the Act and applicable UPL requirements.

Specifically, we are proposing in § 447.302(a) and (b) to codify existing state plan requirements that the plan must provide that the requirements of subpart F are met and that the plan must specify comprehensively the methods and standards used by the agency to set payment rates. We propose in § 447.302(c) that CMS may approve a supplemental payment, as defined in § 447.286, provided for under the state plan or a SPA for a period not to exceed 3 years. A state whose supplemental payment approval period has expired or is expiring may request a SPA to renew the supplemental payment for a subsequent period not to exceed 3 years, consistent with the requirements of § 447.302. A time limited supplemental payment allows CMS and the state an opportunity to revisit state plan supplemental payments to ensure that they remain consistent with efficiency, economy, and quality of care, as required under section 1902(a)(30)(A) of the Act. Over the years, CMS and various oversight bodies conducting financial management reviews and audits have identified areas where unchecked supplemental payments have resulted in payments that appeared to be excessive, and CMS had little recourse to take action. Such audits and financial reviews conducted by CMS or other oversight agencies can take years and require a large number of state and federal resources to complete, and ultimately resolve. As noted earlier in this preamble, in 2015, the GAO issued a report entitled, ''Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy,'' in which it concluded that, ''[w]ithout good data on payments to individual providers, a policy and criteria for assessing whether the payments are economical and efficient, and a process for reviewing such payments, the federal government could be paying states hundreds of millions, or billions, more than what is appropriate.'' [10] As a result, the GAO has recommended that, to better ensure the fiscal integrity of the program, we should establish financial reporting at a provider-specific level and clarify permissible methods for calculating Medicaid supplemental payment amounts. Based on this and other oversight entity recommendations, and

[10] U.S. Gov't Accountability Office, GAO–15–322, Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy, 46 (2015), *https://www.gao.gov/assets/670/669561.pdf.*

CMS' experience administering the Medicaid program at the federal level, we believe that the time-limited approval of supplemental payments is necessary for the proper and efficient operation of state Medicaid plans to ensure the continuing consistency of supplemental payments with applicable statutory requirements and generally to ensure appropriate oversight.

We are not proposing to limit the number of times a state may request, and receive approval for renewal of a supplemental payment program, provided that each request meets all applicable requirements. We propose that a state plan or SPA that would provide for a supplemental payment would be required to include: (1) An explanation of how the state plan or SPA will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including that provision's standards with respect to efficiency, economy, quality of care, and access along with the stated purpose and intended effects of the supplemental payment, for example, with respect to the Medicaid program, providers, and beneficiaries; (2) the criteria to determine which providers are eligible to receive the supplemental payment; (3) a comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including specified content; (4) the duration of the supplemental payment authority (not to exceed 3 years); (5) a monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries; and (6) for a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act. For the state's comprehensive description of the methodology used to calculate the amount, and distribution, of the supplemental payment to each eligible provider as required under item (3), we would require the state to provide all of the following: (1) The amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment; (2) if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed state plan rate year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment; (3) the timing of the supplemental payment to each eligible provider; (4) an assurance that the total Medicaid payment to other inpatient and outpatient facilities, including the supplemental payment, will not exceed the upper limits specified in § 447.325; and (5) if not already submitted, an UPL demonstration as required by § 447.321 and described in proposed § 447.288.

The justification for including the state plan requirements in § 447.302 are the same as those justifications and explanations included in the discussion with regard to § 447.252. We are proposing to require states to provide information necessary to determine that the supplemental payments proposed in the state plan are, and remain, consistent with the efficiency, economy, and quality requirements under section 1902(a)(30)(A) of the Act and the parameters concerning permissible sources of non-federal share under section 1903(w) of the Act.

Finally, in considering the 3-year approval period for supplemental payments, we developed a transition plan to provide states with an adequate opportunity to come into compliance with the proposed requirements. To accomplish the policy objectives described above, we believe we must begin to apply the proposed policies, if they are finalized, to current state plan provisions that authorize supplemental payments that are approved as of the effective date of the final rule. It is no less necessary to ensure the proper and efficient operation of the state plan and ensure that applicable requirements continue to be met, to rigorously evaluate currently existing supplemental payment programs, as it is to do so for new supplemental payment programs approved prospectively. Accordingly, in proposed § 447.302(d), for state plan provisions approved 3 or more years prior to the effective date of the final rule, we propose that the state plan authority would expire 2 calendar years following the effective date of the final rule. For state plan provisions approved less than 3 years prior to the effective date of the final rule, we propose that the state plan authority would expire 3 years following the effective date of the final rule. We believe this is a generous timeline for transitioning to the proposed 3-year time limit for supplemental payments under the state plan. This timeline provides states with currently approved supplemental payment programs with at least 2, and as many as 3 years before a state wishing to continue the supplemental payment program would need to seek renewal or a new approval.

We are soliciting comment on this entire section, including the proposed state plan elements for supplemental payments, and the proposed approval timeframe for a state's proposed supplemental payments. For the timeframes, we are seeking input on both the 3-year approval period and the proposed transition period for currently approved supplemental payments. We considered proposing a 5-year compliance transition period instead of the proposed 3-year compliance transition period in § 447.302(d). This would have increased the amount of time states would have to bring existing, approved supplemental payment methodologies into compliance with the provisions of the proposed rule in §§ 447.252 and 447.302. We decided to propose a 3-year transition period to account for states where changes may require legislative action as some legislatures meet on a biennial basis and such a timeframe would provide an opportunity for all legilslatures to address existing supplemental payment programs. We are requesting comment on whether or not to pursue this or a lengthier transition and approval timeline for supplemental payments.

22. Outpatient Hospital Services: Application of UPLs (§ 447.321)

To promote improved oversight of Medicaid program FFS expenditures for services subject to the UPL, we are proposing changes to § 447.321. Some of the proposed changes to § 447.321 would formally codify current policy, while others are newly proposed. We solicit comment on all proposed provisions.

CMS has long regarded the UPL requirements in § 447.321 and the review of total outpatient hospital Medicaid payments in relation to a provider's cost or the Medicare payment amounts as implementing section 1902(a)(30)(A) of the Act, which requires that states assure that payments are consistent with efficiency, economy, and quality of care. As stated earlier in the preamble, the aggregate application of these UPLs has preserved state flexibility for setting provider-specific payments while creating an overall payment ceiling as a mechanism for

determining economy and efficiency of payment for the services described above, consistent with section 1902(a)(30)(A) of the Act.

We are proposing to change the title of this section to ''Outpatient Hospital Services: Application of upper payment limits'' to remove clinic services from the UPL requirements in § 447.321. The absence of benefit category in the Medicare program similar to Medicaid ''clinic services'' has made establishing and verifying compliance with a UPL for clinic services an overly burdensome task. Without equivalent comparison data from Medicare, it is difficult or impossible to establish a reasonable estimate of what Medicare would pay for Medicaid clinic services, which otherwise would supply the UPL for such services under § 447.321. Additionally, most often, clinics are reimbursed according to the practitioner fee schedule in the same manner as other practitioners under the Medicaid state plan. In these circumstances, we have determined that such payments are not subject to the clinic UPL in any event, because these provider payments are made under the relevant practitioner benefit in the Medicaid program, such as physician services or dental services under sections 1905(a)(5) and (a)(10) of the Act, respectively, rather than clinic services under section 1905(a)(9) of the Act. As with all other inpatient and outpatient facility services, state agencies must continue to apply § 447.325 under which the agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

We have proposed to revise this regulation in the past through other proposed rules, but were unable to finalize those proposals. Particularly, in 2007 with the proposed rule *Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit* (72 FR 55166), we proposed several practical options for states to comply with clinic UPL requirements. Namely, these options included paying at the Medicare non-facility Resource-Based Relative Value Units System (RBRVS) FFS rate for practitioner services in a clinic setting, or setting the rates for services provided in the clinic at the Medicaid state plan rate for the same services when provided by a practitioner under the state plan where there was no Medicare comparable rate. The difficulty in applying the proposals in that particular proposed rule, and difficulties setting and establishing compliance with clinic UPLs since, has been related to the subjectivity of establishing appropriate comparison prices for services where there is no Medicare equivalent, or limiting Medicaid providers to cost when Medicare does not collect or mandate clinic cost reports for free-standing clinics, as is done with other inpatient and outpatient facilities. For these reasons, we are proposing to remove clinic services from § 447.321 so the requirements of the outpatient UPL will no longer apply to these providers and we are requesting comment on this proposed change.

Importantly, this proposal does not mean that the requirements of section 1902(a)(30)(A) of the Act do not continue to apply to clinic payments—emphatically, they do. We simply are proposing to no longer use the clinic UPL as the formal metric of compliance with the efficiency, economy, and quality of care requirements under the statute. We will continue to compare the Medicare RBRVS to Medicaid clinic reimbursement rates, where applicable, to inform administrative decisions about the state's payment rates under section 1902(a)(30)(A) of the Act, much like we do with physician reimbursement under the Medicaid state plan. We are soliciting comment on this particular change in the proposed rule.

We are proposing to amend paragraph (a) to revise the current ownership groups (state government-owned or operated, non-state government owned or operated, and privately-owned and operated facilities) used to establish the UPL. We propose to replace these provider designations with ''state government providers,'' ''non-state government providers,'' and ''private providers.'' We propose to codify the substantive definitions of these provider designations in proposed § 447.286. As discussed below, we would define ''state government provider'' to refer to a health care provider as defined in § 433.52, including those defined in § 447.251, that is a unit of state government or state university teaching hospital; in determining whether a provider is a unit of state government, we would consider the totality of the circumstances, including but not limited to specific considerations identified in proposed § 447.286. Similarly, we would define ''non-state government provider'' to refer to a health care provider as defined in § 433.52, including those defined in § 447.251, that is a unit of local government in a state, including a city, county, special purpose district, or other governmental unit in the state that is not the state, which has access to and exercises administrative control over state funds appropriated to it by the legislature and/or local tax revenue, including the ability to expend such appropriated or tax revenue funds; in determining whether a provider is non-state government provider, we would consider the totality of the circumstances, including but not limited to specific considerations identified in proposed § 447.286. We would define a ''private provider'' to mean a health care provider as defined in § 433.52, including those defined in § 447.251, that is not a state government provider or a non-state government provider.

The proposed changes in provider designations would reinforce the relationship between a provider's designation and its ability (or inability) to provide the source of non-federal share for Medicaid payments. Under the current system of categorization by ownership or operational interests, there can be ambiguity with respect to the appropriate category for a provider when certain responsibilities of ownership or operation are divided between more than one entity. For example, there is currently the possibility that a private nursing facility could transfer the deed to its real property to the county government, but the private entity would continue to administer all functions of the provider as though it were the actual owner, leaving the county government as the owner only in name but not any function. For the provider to make an IGT, the private entity would give funds to the county government, such as through a lease payment for the facility real property, to be used as the source of the non-federal share of Medicaid payments that the state could then make back to the provider in the form of supplemental payments. This effective self-funding of the non-federal share of the supplemental payments by the provider would not have been possible if the provider were categorized as privately owned and operated, since it would have been unable to make the IGT to support the supplemental payments back to it. In this situation, we view this transferred amount as an impermissible source of the non-federal share, since the funds used to support the IGT are not obtained from state or local tax revenue and, as discussed elsewhere in this preamble, would constitute a non-bona fide provider-related donation.

Through the state plan review process and our review of UPL demonstrations, we have observed that some states have re-categorized a number of providers from privately-owned or operated facilities to a governmentally owned or

operated designation, either state government-owned or operated facilities or non-state government-owned or operated facilities. In some instances, the change in ownership category appears to be both a non-bona fide provider-related donation, as well as a device to permit the state to make supplemental payments to a provider and demonstrate compliance with the UPL, rather than reflective of an actual change in the provider's true ownership or operational interests, in view of the apparent continuity of the provider's business structure and activities. We believe this shift in designation has facilitated higher supplemental payments to certain providers, without the state incurring additional cost to fund the non-federal share of payment where the private operator passes funds to the new governmental owner, which constitutes a non-bona fide provider-related donation, and those funds are either used to make an IGT or supplant funds that are otherwise used to make an IGT to the state to make a supplemental payment targeted toward the private entity. We are concerned that this type of arrangement is not consistent with the basic construct of the Medicaid program as a cooperative federal-state partnership where each party shares in the cost of providing medical assistance to beneficiaries.

Similar to our proposal in § 447.272, we propose to amend § 447.321(b) to clarify that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in 42 CFR chapter IV, subchapter B, or allowed costs established in accordance with the cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in 42 CFR part 413. The specific data elements, methodology parameters, and acceptable UPL demonstration methodologies are specified in proposed § 447.288(b).

The existing regulations simply state that the UPL refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of title 42, chapter IV, of the CFR, which provided CMS with the ability to define UPLs as a payment limit set at the aggregate amount that Medicare would have paid for the same Medicaid services using either a Medicare payment methodology or Medicare cost principles. These two methods are employed because these are the two methods that Medicare has historically used to pay for services as authorized under title 42, chapter IV, subchapter B, of the CFR. In establishing this limit, we have required that states set the UPL using these principles, then compare the aggregate Medicaid payments for the defined period to the UPL, which is the Medicare equivalent payment or cost amount. We are proposing to codify our existing policy related to the use of the two methods of demonstrating the Medicaid UPL, by using the Medicare equivalent payment amount or cost amount, and the process for establishing and demonstrating compliance with the UPL in § 477.288(b) of this proposed rule. As noted elsewhere in this proposed rule, the term ''Medicare equivalent'' means the Medicare equivalent to the Medicaid data, payment, or services. Therefore, the term Medicare equivalent payment means the amount that would be paid for Medicaid services furnished by the group of providers if those services were provided to Medicare beneficiaries and paid under Medicare payment principles. Likewise, a reference to Medicare equivalent charges in reference to a UPL calculation means the Medicare charges for the same Medicaid services subject to the UPL.

We considered proposing to define specific methods by which states would be required to demonstrate compliance with the UPL in each of §§ 447.272 and 447.321, but determined that the proposed § 447.288 would allow us to define necessary data elements, parameters, and methodologies for demonstrating compliance with UPLs in one location, for purposes of both the inpatient and outpatient UPLs under §§ 447.272 and 447.321, respectively. To summarize briefly, proposed § 447.288 describes the data sources, data parameters, and methodologies that must be considered and used in demonstrating compliance with the UPL. It describes the appropriate Medicare data and the creation of ratios using either cost or payment data calculations, the Medicaid charge data which multiplied by the either a ratio of cost-to-charge (total cost or Medicare cost) or the ratio of Medicare payment-to-charge to calculate the UPL amount and any associated considerations (inflation adjustments, utilization adjustments, or other cost adjustments), and the Medicaid payment data. For a detailed discussion of these proposed UPL requirements, please refer to the discussion above related to § 447.288.

We invite comment on all proposed new and revised provisions in this section.

23. Medicaid Practitioner Supplemental Payments (§ 447.406)

For a number of years, states have been making supplemental payments that are targeted to certain practitioners, such as physicians and other licensed professionals, under the Medicaid state plan. Most commonly, states have targeted supplemental payments to practitioners affiliated with and furnishing services in academic medical centers and safety net hospitals. These payments have used what is commonly described as an ACR calculation. The ACR is a method of calculating an average rate paid by commercial third party payers for specific medical service codes (usually Current Procedural Terminology (CPT) codes) to providers and multiplying that average rate by the Medicaid claims for each code to establish an upper limit for these practitioner supplemental payments.

Predominantly, such ACR payments are funded by IGTs from local government sources or state university teaching hospitals and are generally made without consideration of improvements in access to or quality of care. When payment is made up to the ACR, states submit data to CMS from the top (generally five) commercial payers and provide an explanation of the data that was extracted from providers' accounts receivable systems. The state compares payment by Medicaid for each billing code to the average payment amount allowed by commercial payers for the same services. Data from each of the practitioners, group practices, or hospital-based practitioner groups eligible to receive the supplement payment is included in the submitted ACR calculation. These calculations are usually completed by the provider(s) and sent to CMS by the states through the submission of SPAs. We are proposing to end the practically unrestricted use of ACR supplemental payments based on concerns that the payments are not economic and efficient, consistent with section 1902(a)(30)(A) of the Act, and that they present a clear oversight risk because they are based on proprietary commercial payment data and thus not verifiable or auditable. As discussed in detail below, we are proposing to limit Medicaid practitioner supplemental payments to 50 percent of FFS base payments to the eligible provider for practitioner services, or 75 percent of such payments for services provided within HHS' Health Resources and Services Administration (HRSA)-designated geographic health professional shortage areas (HPSAs) or

Medicare-defined rural areas, as specified in 42 CFR 412.64(b), as discussed below.

When ACR-based payments were first approved in 2000, we found that state ACR amounts were between 150 percent and 165 percent of the Medicare rates for the same services. In recent years, however, states have sought to make Medicaid practitioner supplemental payments based on calculations reflecting amounts of approximately 300 percent to 400 percent of the Medicare rate. While these percentage are outliers among states making ACR payments, those amounts were considerably larger than we had otherwise seen. In federal FY 2018, the most recent full fiscal year for which data was reported, states claimed approximately $1.32 billion in (total computable) expenditures for supplemental payments made to physicians and other licensed practitioners. As states and practitioners realized that Medicaid payments could be increased through the use of ACR-based supplemental payment methodologies and with funding from IGTs, states began to explore expanding the ACR-based supplemental payments to other Medicaid participating practitioners.

Although we questioned whether making Medicaid payments at up to 400 percent of Medicare rates was consistent with economy and efficiency as required under section 1902(a)(30)(A) of the Act, we continued to approve ACR methodologies submitted by states consistent with our historic view that such methodologies that relied on commercial data were permissible under the relevant statutory standards, and because we had not established an upper bound for practitioner supplemental payments through rulemaking.

In this rule, except as discussed below, we are proposing to apply the definitions applicable to base and supplemental payments defined under newly proposed § 447.286—Definitions and the proposed new requirements in § 447.302—State plan requirements. By aligning these definitions and requirements, we are ensuring that the terminology for base and supplemental payments for practitioner services is consistent with other service types and that states apply the same comprehensive descriptions and time limits to practitioner supplemental payments as would be applied to other Medicaid service supplemental payments. Further, we are proposing, within § 447.406(c), to limit Medicaid practitioner supplemental payments relative to base payments set under the Medicaid state plan. Notably, lump sum provider quality incentive supplemental payments that are targeted to a subset of providers within the state as part of a state's delivery system reform initiative and paid based on improvements to reported quality measures are included in the definition of ''Supplemental payment'' under proposed § 447.286, for purposes of newly proposed § 447.406, and therefore, would be subject to the limit proposed in § 447.406. To the extent that value-based payment methodologies that are part of a state's delivery system reform initiative and that are available to all providers under a Medicaid benefit category, including as an alternative to FFS payment rates (for example, bundled payment methodologies, payments for episodes of care, Medicaid shared savings methodologies), and otherwise align with the definition of base payments in § 447.286 (for example, the payment can be attributed to a particular service provided to a Medicaid beneficiary), we propose such payments to be base payments as defined in § 447.286. This consideration is consistent with the proposed definitions of base and supplemental payments and will allow states sufficient flexibility to promote quality improvement which may result in better care and reduced program cost over time.

The proposed new limits would allow states to target supplemental payments to practitioners: (1) Up to 50 percent of the FFS base payments authorized under the state plan for the practitioner services paid to the eligible provider during the period covered by the supplemental payment, or (2) for services provided within HRSA-designated geographic HPSA or Medicare-defined rural areas as defined in § 412.64(b), Medicaid practitioner supplemental payments could be made up to 75 percent of the FFS base payments authorized under the state plan for the practitioner services paid to the eligible provider during the period covered by the supplemental payment. We are proposing to permit additional payment for practitioner services in geopgraphic HPSAs to allow states flexibility to increase payment rates and address professional shortages and access to care concerns in areas where HHS has determined such shortages exist. Likewise, we are proposing to include Medicare-defined rural areas as defined in § 412.64(b) because states have frequently identified rural areas, some of which may not be included in the geographic HPSAs, as having issues related to access to care and we want to provide states with the flexibility to make increased practitioner supplemental payments if the state determines that such increases are needed in those areas as well.

We believe these percentages are appropriate because the ACR data from 2016 and 2017 show that, nationally, among providers receiving an ACR supplemental payment, total supplemental payments equaled approximately 75 percent of the base payment rates in 2016 to approximately 93 percent of the base payment rates in 2017 (total supplemental payment divided by total base payments to qualifying provider) based on data received through the state UPL demonstration submissions. By limiting the total practitioner payment, base and supplemental payment, to 150 percent of the base Medicaid practitioner payment, or 175 percent of the base Medicaid practitioner payment for services provided in a HRSA-designated geographic HPSA or a Medicare-defined rural area, we believe that the proposed policy would not diverge excessively from ACR supplemental payments that we historically have approved. However, under the prior structure, the supplemental payment was not related to the base Medicaid payment and could only be increased based on changes to the commercial payer rates. Therefore, an increase in the base Medicaid payment could not result in an increase in a supplemental payment to eligible providers, as would be possible under our proposal. If a state wants to increase a provider's supplemental payment beyond the maximum amount that would be permissible under the proposed provision, the state could increase Medicaid base payment rates, which could enable the state to pay a further 50 percent (or 75 percent) of the increase in FFS base payments to eligible providers. We believe this approach is, first, consistent with section 1902(a)(30)(A) of the Act, and, second, is sufficiently consistent with the previously approved Medicaid ACRs amounts not to excessively disturb total provider payments being made today under previously approved ACR supplemental payment arrangements.

To provide an example of the application of the proposed Medicaid practitioner supplemental payment limit, assume the state has proposed to make a supplemental payment to a group of practitioners within an area of the state that is not a HRSA-designated geographic HPSA or Medicare-defined rural area. One of the qualifying providers received total Medicaid FFS base payments for practitioner services of $100,000 and the state wishes to make a supplemental payment to that provider. The proposed ceiling

methodology results in the following calculation: $100,000 total Medicaid base payments × 0.50 = $50,000, which could allow the state to make a Medicaid practitioner supplemental payment to the provider of up to $50,000, in addition to the Medicaid FFS base payment of $100,000, for a total payment to the provider of up to $150,000. However, if the Medicaid practitioner supplemental payment were made to a provider for services furnished in one of the HRSA-designated geographic HPSAs or a Medicare-defined rural area, the supplemental payment ceiling would be 75 percent of the total base payment amount of $100,000, which would result in the following ceiling calculation: $100,000 total Medicaid base payment × 0.75 = $75,000, which could allow the state to make a Medicaid practitioner supplemental payment of up to $75,000, in addition to the Medicaid FFS base payment of $100,000, for a total payment to the provider of up to $175,000.

In this proposed rule, we propose definitions of the terms ''base payment'' and ''supplemental payment'' in § 447.286. Per those proposed definitions, we consider Medicaid practitioner supplemental payments as ''supplemental'' payments under the proposed definitions. The reason is that the base payments are payments made to a provider for specific services provided to an individual beneficiary. While Medicaid practitioner supplemental payments could be tied to individual services, the calculation of the final payment amount is not dependent upon specific services furnished to any individual beneficiary, or any beneficiary's acuity or complexity of care received, nor is the practitioner supplemental payment made only for complex cases. Base payments for all practitioner services furnished by the eligible provider are supplemented by the supplemental payment, regardless of the level of beneficiary acuity or complexity (as typically would be relevant to payment adjustments or add-ons that would be considered part of the base payment). The eligible provider qualifies for these payments based on state-developed criteria that target certain providers, and the supplemental payments are often paid as lump sum at the end of a quarter or at the end of year.

In proposing these requirements, we are seeking to establish an appropriate and auditable upper bound to better ensure that practitioner payments are consistent with economy and efficiency by ensuring the supplemental payments have a reasonable relationship to the base rate methodologies that have been approved by CMS on the basis of our determination that such base rate methodologies are consistent with statutory requirements. The ACR supplemental payments historically have been established based on the negotiating power of various actors in the private market and without regard to the unique circumstances of the Medicaid program, including statutory requirements to ensure efficiency and economy. That is, higher reported commercial payment rates are a function of practitioners' ability to negotiate higher rates from certain commercial payers, rather than a result of prevailing rates generally paid to practitioners by all commercial payers, or all payers generally, and without any necessary analysis of economy and efficiency.

In contrast, the proposed provisions intend to tie the highest practitioner payments in the state to the lowest (that is, payments to practitioners that are limited to the state plan FFS base payment). States have already determined and declared as part of their rate-setting processes that base payments are consistent with economy and efficiency, quality of care, and access to care requirements, as required under section 1902(a)(30)(A) of the Act. Therefore, we believe that setting the upper limit for targeted practitioner supplemental payments at 50 percent or 75 percent more than the base amounts is reasonably sufficient to allow states with flexibility, when needed, to target payment increases while providing a basis to gauge that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. State payments must meet both tests of section 1902(a)(30)(A) of the Act in that a base payment may be economic and efficient, but if it is not sufficient to enlist sufficient providers in a particular area of the state, then an increase in payments may be needed to ensure that the rates are sufficient to enlist adequate numbers of providers in the Medicaid program. Further, this proposed policy may encourage states to evaluate whether Medicaid payment rates are generally consistent with section 1902(a)(30)(A) of the Act across all practitioners within a geographic region and evaluate whether rate increases for all practitioners may be necessary to improve access or quality, rather than targeting payments to certain practitioners that may be in a position to provide the non-federal share in exchange for supplemental payments.

Our concerns over the growing scope of practitioner supplemental payments relate to both the payment amounts relative to Medicare rates and the practitioners to which the states are providing the payments, which appears to be largely driven by the source of non-federal share used to fund the payments. As states typically rely on the providers that receive the supplemental payments to fund the non-federal share through IGTs, there is less incentive for the states to properly oversee the payments and ensure that the amounts are economic and efficient. Typically when states use appropriated funds as the source of non-federal share there is a meaningful state interest in ensuring value to maintain state budgets; however, when the non-federal share is provided by the service provider (and returned with matched federal funds through the supplemental payments) there is an inherent incentive to maximize the amount of the payments to providers in the state. In almost all instances, the providers were supplying the state with the non-federal share of the Medicaid physician supplemental payments. Without the supplemental payments, it is likely that the arrangements through which the providers have been transferring the state share to the state Medicaid agency to support current high levels of Medicaid practitioner supplemental payments would cease, and therefore, the net impact on the providers would be far less than the projected amount of decrease in practitioner supplemental payments.

The incentive to maximize federal funds to providers and lack of oversight interest from states is particularly problematic in the case of practitioner supplemental payments because of the data sources used for ACR demonstrations. The data currently used to determine supplemental payment amounts is based entirely on proprietary commercial payment data supplied by the practitioners who themselves stand to benefit from the supplemental payment. In our reviews, we have not been able to verify that the commercial payment data is correct or genuinely representative of rates that the commercial market will bear. We have also found, in several instances, that the data has been manipulated to increase the potential supplemental payments by, for instance, using comparisons to Medicaid rates paid for services within facilities (which are generally lower than office settings) compared to non-facility commercial rates, or by

foregoing appropriate adjustments to ensure that the time and associated payments for procedures are equivalent for Medicaid and commercial data. Since the data within the ACR demonstrations are produced by providers (and masked to protect proprietary information), the demonstrations are impossible to validate, difficult to interpret and ultimately may not be auditable in accordance with § 430.33. By setting a limit based on Medicaid-based rates, as proposed under this rule, data is readily available within state and CMS claims systems to validate and audit the supplemental payment amounts.

We recognize that states that are already making ACR-based supplemental payments may need time to come into compliance with the proposed new limits, if they are finalized. For states whose state plans currently provide for Medicaid practitioner supplemental payments, we are proposing in § 447.406(d) to provide a transition period consistent with the one defined in § 447.302(d) for the state to submit a SPA to bring its currently approved Medicaid supplemental practitioner payment program into compliance with the requirements proposed in this section, including the cross-referenced requirements in § 447.302. Specifically, we propose that, for Medicaid practitioner supplemental payments that were approved on or before the effective date of any final rule, the state would be required to submit and obtain CMS approval for a SPA to comply with the requirements of this section in order to continue making such supplemental payments. Otherwise, the authority for state plan provisions that authorize the Medicaid practitioner supplemental payments that are approved as of the effective date of any final rule would be limited according to the timeframe described in § 447.302(d). By the end of the transition period, a state without an approved SPA bringing the Medicaid practitioner supplemental payment program into compliance with the requirements of this section (and, as incorporated by cross reference, of § 447.302) would not be authorized to continue making the supplemental payments. We believe this approach to a transition period would help minimize burden on states, as states with Medicaid practitioner supplemental payment programs would have a generous period of time to bring their state plans into compliance with the proposed new requirements. Additionally, we propose that states would no longer be required to submit annual ACR demonstrations for the annual UPL submission requirements outlined in the SMDL 13–003 for states that make targeted physician supplemental payments for physician services, further reducing the associated state burden. Instead, CMS expects that the state plan would include a comprehensive written statement of the Medicaid FFS base payment and Medicaid practitioner supplemental payment methodologies, in a manner consistent with §§ 447.302, 447.406, and all other applicable requirements.

We are seeking comment on all elements of this proposal, including the level of the proposed ceiling percentages (and whether they should be higher or lower), the option of using the Medicare rural areas and/or HRSA-designated geographic HPSA to target eligible providers for supplemental payments, the language regarding value-based payment methodologies, and whether there would be other appropriate means to give states flexibility to offer special consideration for providers in underserved areas.

24. Definitions (§ 455.301)

We are proposing to revise the definition of the ''independent certified audit'' to include the requirement for auditors to quantify the financial impact of each audit finding, or caveat, on an individual basis, for each hospital, per the reporting requirement in § 447.299(c)(21) and under section 1923(j)(1)(B) of the Act. Additionally, we propose to include in the definition how a certification of the audit would include a determination of whether or not the state made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid state plan rate year under audit. Specifically, we are proposing to add to annual DSH reporting a requirement for auditors to quantify the financial impact of any finding, including those resulting from incomplete or missing data, which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit. As previously discussed, based on the audit results we are often unable to determine whether a DSH overpayment to a provider has occurred, the underlying causes of the overpayments, and the amount of the overpayments associated with each cause. This is the result of an auditor including an audit finding indicating that the missing information may have an impact on the calculation of total eligible uncompensated care costs while not making a determination of the actual financial impact of the identified issue. As a result of this lack of quantification of the financial impact of this finding, we are unable to determine whether an overpayment, if any, has resulted from this audit finding. As such, revising the definition is necessary in promoting oversight and integrity of the DSH program and ensuring the audit and report results allow us to calculate accurate hospital-specific limits. We are soliciting comments related to this proposed change.

25. Process and Calculation of State Allotments for Fiscal Year After FY 2008 (§ 457.609)

We are using the opportunity within this regulation to revise the method for notifying states and the public of national CHIP allotments. Section 2104 of the Act provides appropriations for fiscal year CHIP allotments for FYs 1998–2027 as determined under the methodologies provided in sections 2104(b), 2104(c), and 2104(m) of the Act as applicable for payments to states as described in section 2105 of the Act. Section 457.609 describes the process and calculation of state allotments for a fiscal year after FY 2008. Section 457.609(h) provides that CHIP Allotments for a fiscal year may be published as preliminary or final allotments in the **Federal Register** as determined by the Secretary. We have not published CHIP allotments in the **Federal Register** since the FY 2013 CHIP allotments. Each year following FY 2013, states have been notified of their CHIP allotments through either email notifications and/or through MBES/CBES. We propose to remove from § 457.609 the reference to our discretionary option to publish in the **Federal Register** the national CHIP allotment amounts as determined on an annual basis for the fiscal years specified in statute. Instead, we are proposing to post CHIP allotments in the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) and at *Medicaid.gov* (or similar successor systems or websites) annually. We believe that posting the CHIP allotment amounts at *Medicaid.gov* and in the MBES/CBES is an efficient way to make the information more easily accessible to interested stakeholders and would be less administratively burdensome for CMS. We are soliciting any comments related to these proposed changes.

III. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We would consider all comments we receive by the date and time specified in the **DATES** section of

this preamble, and, when we proceed with a subsequent document, we would respond to the comments in the preamble to that document.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), we are required to publish a 60-day notice in the **Federal Register** and solicit public comment before a ''collection of information'' requirement is submitted to the Office of Management and Budget (OMB) for review and approval. For the purposes of the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

To fairly evaluate whether an information collection should be approved by OMB, PRA section 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs).

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2018 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). In this regard, Table 1 presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 1—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Accountants and auditors	13–2011	37.89	37.89	75.78
Data Entry Keyers	43–9021	16.22	16.22	32.44
Financial Specialist all other	13–2099	37.30	37.30	74.60
General and Operations Managers	11–1021	59.56	59.56	119.12
Healthcare Support Workers all other	31–9099	18.80	18.80	37.60
Managers all other	11–9199	55.57	55.57	111.14
Social Science Research Assistants	19–4061	24.24	24.24	48.48

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. Proposed Information Collection Requirements (ICRs)

The following regulatory sections of this rule contain proposed collection of information requirements (or ''ICRs'') that are subject to OMB approval under the authority of the PRA: §§ 433.72 (Waiver provision applicable to health care related taxes), 447.252 and 447.302 (State plan requirements), 447.288 (Reporting requirements for UPL demonstrations and supplemental payments), and 447.299 (DSH reporting requirements). Our analysis of the proposed requirements and burden follow.

1. ICRs Regarding Tax Waiver Requirements (§ 443.72)

The following proposed changes will be submitted to OMB for approval under control number 0938–0618 (CMS–R–148). Subject to renewal, the control number is currently set to expire on February 28, 2021. It was last approved on February 9, 2018, and remains active.

Section 433.72 of this rule proposes to add a period of validity for tax waivers of the broad-based and/or uniformity requirements, which states that waivers will cease to be effective 3 years from CMS' approval in the case of tax programs commencing on or after the rule's effective date or 3 years from the rule's effective date in the case of waivers approved before the rule's effective date. This change is necessary because the provider data submitted by states to CMS, for use in the statistical tests described at § 433.68, may change over time. As a result, the tax may be generally redistributive as required by statute and regulation when the state requests the waiver, but may subsequently cease to be so. Currently there are approximately 35 states that have broad based or uniformity waivers. We propose to allow states with existing health care-related tax waivers up to 3-years from the effective date of the final rule before they must seek re-approval. This will provide states sufficient time to evaluate and, if necessary, modify existing tax programs.

The ongoing burden associated with the proposed requirements consists of the time it would take each state that has an existing tax waiver to submit an updated version within 3-years after the effective date of the final rule and to update the waiver every 3 years. Of the 35 states with tax waivers, we estimate that there are approximately 60 tax waivers that will have to be renewed every 3 years, or about 20 tax waivers renewed per year by various states (0.4 tax waiver renewals per year per state). Please note that the proposed waiver requirements are minimal, as states are already required to monitor and update their tax waivers to ensure compliance with federal requirements.

We estimate it would take 2 hours at $37.60/hr for a healthcare support worker to prepare and submit an updated tax waiver. In aggregate we estimate an ongoing annual burden of 40 hours (20 tax waiver renewals per year × 2 hr/renewal) at a cost of $1,504 (40 hr × $37.60/hr) or $30 per state ($1,504/51).

2. ICRs Regarding State Plan Requirements (§§ 447.252 and 447.302)

The following proposed changes will be submitted to OMB for approval under control number 0938–0193 (CMS–179). Subject to renewal, the control number is currently set to expire on April 30, 2022. It was last approved on April 9, 2019, and remains active.

The proposed changes to §§ 447.252 and 447.302 would require that states provide additional descriptors for any proposed supplemental payments and would put a 3-year limit on the duration of all prospectively approved supplemental payments, with a transition period for states to seek renewal of currently approved supplemental payments in accordance with the proposed requirements, if the state desires to continue the supplemental payment. States would need to provide the additional descriptors to receive state plan authority to disburse their proposed supplemental payments. Consequently, currently approved supplemental payment-related SPAs would have to be updated by adding the descriptors, as outlined in section II.A.13. of this proposed rule, state plan requirements (§ 447.252), and in § 447.252(d) of the regulatory text. Supplemental payments are presently authorized through the SPA process with CMS.

The ongoing burden associated with the proposed requirements consists of the time it would take each of the 50 state Medicaid programs, the District of Columbia, and the territories Puerto Rico, US Virgin Islands, and Guam (hereinafter, ''states'') to specify six (6) descriptors for all applicable SPAs that provide or would provide for a supplemental payment. The territories the Commonwealth of the Northern Mariana Islands (CNMI) and American Samoa have been excluded to the extent that Medicaid services are provided under section 1902(j) waiver. The additional SPA descriptors include: (1) An explanation of how the state plan or SPA will result in payments that are consistent with section 1902(a)(30)(A) of the Act; (2) the criteria to determine which providers are eligible to receive the supplemental payment; (3) a comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including all of the following: The amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment, if applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed SPA year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment, the timing of the supplemental payment to each eligible provider, an assurance that the total Medicaid payment to an inpatient hospital provider, including the supplemental payment, will not exceed the upper limits specified in § 447.271, and if not already submitted, a UPL demonstration as required by § 447.272 and described in § 447.288; (4) the duration of the supplemental payment authority (not to exceed 3 years); (5) a monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries; and (6) for a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act.

We have attempted to mitigate any new burden by identifying the essential descriptors that are necessary during a SPA review of proposed state supplemental payments. The more information and transparency provided with the SPA to implement new, or renew existing, supplemental payments will reduce the number of questions and requests for additional information from CMS, and therefore, could result in more expedited approval along with increased economy and efficiency of the Medicaid program.

To estimate the overall burden of adding the descriptors to all supplemental payment-related SPAs we considered the total nationwide number of active supplemental payments by states reporting for the current 8 UPL demonstration service types for the period 2015–2017 (3 years) in the proposed 6 UPL service types (see Table 2, line A): (1) Nursing facility; (2) outpatient hospital; (3) inpatient hospital; (4) ICF/IID; (5) IMD; and (6) physician services excluding PRTF and clinic.

As indicated, the total number of states reporting supplemental payment methodologies in the UPL demonstrations in the Medicaid program for the following service types are: 37 for inpatient hospital services (IP); 29 for outpatient facility services (OP); 49 for nursing facility services (NF); 8 for ICF/IIDs (ICF); 0 for IMDs (IMD); and 17 for physician services (Phys). We recognize that there are often more than one supplemental payment SPA per state for each service type, especially for states with more providers and service types like inpatient hospitals and nursing facilities, while IMDs have no supplemental payments, and therefore, no SPAs to renew or submit. To account for this we multiplied the number of states reporting each service type by 2 (approximately 2 SPAs per year for each service type) to estimate the total number of SPAs submitted by the states.

In this regard, the total number of SPAs is estimated to be 280 (Table 2, line B) or 5.19 (line C) per state (280 SPAs/54 states and territories). We estimate that each SPA is renewed every 2.5 years (half of the time required in this proposed rule), for 2.08 (5.19 SPAs per state/1 SPA renewal every 2.5 years) SPA renewals per state per year.

TABLE 2—STATE REPORTING OF SUPPLEMENTAL PAYMENT METHODOLOGIES IN THE UPL DEMONSTRATIONS

UPL demonstration types	IP	OP	NF	ICF	IMD	Phys	Total
A. Supplemental Payment Methodologies reported by States	37	29	49	8	0	17	140
B. SPA multiplier × 2	74	58	98	16	0	34	280
C. SPAs needed to be renewed per year per state (B/54 states)	1.37	1.07	1.81	0.30	0.00	0.67	5.19

We estimate it would take 30 additional minutes (0.5 hr) at $48.48/hr for a social science research assistant (technical staff) to add all 6 supplemental payment SPA components from §§ 447.252 and 447.302 for each SPA submission, noting that a comprehensive payment methodology is currently required for all SPA submissions. In aggregate, we estimate an annual burden of 56.2 hours (2.08 SPA renewals per state per year × 0.5 hr for additional descriptors × 54 states and territories) at a cost of $2,725 (56.2 hr × $48.48/hr). This estimate

factors in the burden associated with supplemental payment SPAs for the 6 service types mentioned above and summarized in Table 2. Per state, we estimate an average annual burden of 1.0 hours (56.2 hr/54 states and territories) at a cost of $50 ($2,725/54 states and territories).

3. ICRs Regarding Reporting for UPL Demonstrations and Supplemental Payments (§ 447.288)

The following proposed changes will be submitted to OMB for approval under control number 0938–1148 (CMS–10398 #13 and #24). Subject to renewal, the control number is currently set to expire on March 31, 2021. It was last approved on March 1, 2018, and remains active.

Section 447.288 of this rule proposes to codify our current policy of requiring states and territories to submit annual UPL demonstrations.

While the territories Puerto Rico, US Virgin Islands, and Guam are included in this estimate, the Commonwealth of the Northern Mariana Islands (CNMI) and American Samoa have been excluded from this estimate because they provide Medicaid services under section 1902(j) waivers. The proposed rule would also add quarterly reporting requirements (§ 447.288(c)(1)) that would provide data on each provider receiving a supplemental payment, the amount of payment(s), and the state plan/demonstration authority authorizing the payment. The proposed rule would also require an aggregate report (§ 447.288(c)(2)) of all providers receiving supplemental payments that totals all of the supplemental payments providers receive during the year plus all Medicaid payments, and Medicaid utilization data. Lastly, the rule would also require a report (§ 447.288(c)(3)) of all of those providers contributing to the state's non-federal share for any supplemental payment, the state plan/demonstration authority authorizing the payment, and the amount of the payment(s).

(1) UPL Demonstrations

The currently approved burden associated with the requirements we are revising and putting into regulation in this proposed rule, consists of the time it would take each of the 56 Medicaid programs (50 states, 5 territories, and the District of Columbia) to submit annual UPL demonstrations and report supplemental payments for: Inpatient hospital; outpatient hospital; nursing facilities; PRTF; clinic services; other inpatient & outpatient facility providers (commonly known as physician services); ICF/IID; and institutions for mental disease (IMD) on the currently approved (hereinafter, ''active'') UPL templates that are set out under CMS–10398 #13 and #24.

This proposed rule would reduce burden by eliminating the UPL demonstrations for three service types PRTF, clinic services, and other inpatient & outpatient facility providers (physician services) and by eliminating 2 territories from reporting any of the items required under § 447.288. It also proposes to codify the requirements for states to annually report UPL demonstrations as discussed in SMDL #13–003 (March 18, 2013),[11] which was associated with OMB approved templates (OMB Control Number 0938–1148) and collection of information requirements approved by OMB under control number 0938–1148 (CMS–10398 #13 and 24).

For CMS–10398 #13 (Medicaid Accountability—Nursing Facility, Outpatient Hospital and Inpatient Hospital Upper Payment Limits) eliminating 2 territories from this reporting would reduce our active burden estimates by −80 hours (40 hr/response × −2 responses) for a burden reduction of $3,057 ([30 hr × −2 responses × $32.44/hr for a data entry keyer] + [9 hr × −2 responses × $48.48/hr for a social science research assistant] + [1 hr × −2 responses × $119.12/hr for a general and operations manager]).

For CMS–10398 #24 (Medicaid Accountability—Upper Payment Limits ICF/IID, Clinic Services, Medicaid Qualified Practitioner Services and Other Inpatient & Outpatient Facility Providers) this would reduce our active burden by −80 hours (40 hr/response × −2 responses) at a cost of −$3,057 ([30 hr × −2 responses × $32.44/hr for a data entry keyer] + [9 hr × −2 responses × $48.48/hr for a social science research assistant] + [1 hr × −2 responses × $119.12/hr for a general and operations manager]).

For CMS–10398 #24 this rule would also reduce our active burden by eliminating 3 of the 5 UPL demonstrations for the service types PRTF, Clinic Services, and Medicaid Qualified Practitioner Services and Other Inpatient & Outpatient Facility Providers (commonly referred to as the physician ACR). This would reduce our active burden estimates by −1,296 hours (8 hr/response × 3 service types × 54 states) for a savings of $49,528 ([18 hr × −54 states × $32.44/hr for a data entry keyer] + [5.4 hr × −54 states × $48.48/hr for a social science research assistant] + [0.6 hr × −54 states × $119.12/hr for a general and operations manager]). This proposed action would thereby eliminate the PRTF, Clinic Services, and Medicaid Qualified Practitioner Services and Other Inpatient & Outpatient Facility Providers (commonly referred to as physician ACR) templates along with the guidance and instruction documents that are associated with the templates.

As indicated, the proposed burden changes will be submitted to OMB for approval under control number 0938–1148 (CMS–10398 #13 and #24). Since the proposed requirements impact two information collection requests (#13 and #24), we estimate a total burden reduction of −1,456 hours (−80 hr −80 hr −1,296 hr) for a savings of $55,642 (−$3,057 −$3,057 −$49,528).

(2) Quarterly Reporting of Expenditures Claimed for Each Supplemental Payment (§ 447.288(c)(1))

In addition to the data already collected in the aggregate for all supplemental payments and required annually for UPL demonstrations under the CMS–10398 #13 and #24, this proposed rule would require that states report information quarterly on expenditures claimed for each supplemental payment made under state plan or demonstration authority including: (1) The SPA transaction number or demonstration authority number which authorizes the payment; (2) a listing of each provider that received a payment under each authority by the specialty type (if applicable, for example, CAH, pediatric hospital, or teaching hospital); (3) the specific amount of the supplemental payment paid to each provider including the total payment made to the provider authorized under the specified state plan; and (4) the total Medicaid payment made to the provider under the specified demonstration authority.

This rule would add quarterly data reported to CMS in the form of 5 new templates mirroring the UPL demonstrations reporting by service type of the provider. For CMS–10398 #13, this would consist of quarterly report templates for: Nursing facilities, outpatient hospitals, and inpatient hospitals. For CMS–10398 #24, quarterly report templates would be added for: ICF/IID and IMD.

The quarterly reports would be required at the time the state submits its quarterly CMS–64 (OMB control number 0938–1265) pursuant to § 430.30(c), consisting of provider level information on all providers receiving supplemental payments, including 11

[11] Center for Medicaid and CHIP Services, *RE: Federal and State Oversight of Medicaid Expenditures,* State Medicaid Director's letter SMD #13–003, accessed 4/9/2019: *https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-2.pdf.*

data elements consisting of 8 demographic elements and 3 elements specific to supplemental payments (see (§ 447.288(c)(1))). The 8 demographic elements of each provider that received a supplemental payment under each authority consist of: (1) The provider's legal name; (2) the physical address of the location or facility where services are provided, including street address, city, state, and ZIP code; (3) the NPI; (4) the Medicaid identification number; (5) the EIN; (6) the service type for which the reported payment was made;(7) the provider specialty type (if applicable, for example, CAH, pediatric hospital, or teaching hospital); and (8) the provider category (that is, state government, non-state government, or private). The 3 supplemental payment elements for payments paid to each provider consist of the specific amount of the supplemental payment made to the provider, including: (1) SPA transaction number or demonstration authority number which authorizes the supplemental payment; (2) the total supplemental payment made to the provider authorized under the specified state plan; (3) the total Medicaid supplemental payment made to the provider under the specified demonstration authority, as applicable.

For the supplemental payment quarterly reports, annually we estimate it will take 20 seconds at $32.44/hr for a data entry keyer to query states' MMIS system and/or copy and paste each data element into the required format for reporting. The initial quarterly report would require the full set of 11 data elements for each provider receiving a supplemental payment with a burden of 449 hours (7,341 providers with supplemental payments × 11 data elements × 1 report/year × 20 seconds/3,600 seconds in an hour) and a cost of $14,566 (449 hr × $32.44/hr).

The three (3) subsequent quarterly reports would only require reporting of the three (3) supplemental payment data elements since the eight (8) demographic data elements would have already been reported in the initial quarterly report. The burden associated with the subsequent reports consists of 367 hours (7,341 providers with supplemental payment × 3 data elements × 3 reports/year × 20 seconds/3,600) at a cost of $11,906 (367 hr × $32.44/hr).

In aggregate, we estimate a burden of 816 hours (449 hr + 367 hr) at a cost of $26,472 ($14,566 + $11,906).

We also expect oversight by social science research assistants and general operations managers for each of the supplemental payment quarterly reports. We estimate it would take 1 hour at $48.48/hr for a social science research assistant and 30 minutes (0.5 hr) for a general operations manager at $119.12/hr to review each of the reports. In this regard we estimate an annual burden of 306 hours ([1 hr × 4 reports × 51 states] + [0.5 hr × 4 reports × 51 states]) at a cost of $22,040 ([1 hr × 4 reports × 51 states × $48.48/hr] + [0.5 hr × 4 reports × 51 states × $119.12/hr]).

Given the aforementioned burden estimates, we estimate a total of 1,140 hours (816 hr + 324 hr) at a cost of $49,797 ($26,460 + $23,337) for all of the information collection requests with quarterly reporting, including all 5 new templates. Per state we estimate 21.1 hours (1,140 hrs/54 states) and $922 (49,797/54 states) for all quarterly reporting.

As indicated, the proposed requirements and burden will be submitted to OMB for approval under control number 0938–1148 (CMS–10398 #13 and #24). Since the proposed requirements would impact two information collection requests (CMS–10398 #13 and #24), the annual quarterly reporting burden for each is broken down here: For CMS–10398 #13 (new quarterly report templates for inpatient hospitals, outpatient hospitals, and nursing facilities) it is 1,108 hours (1,122 hr × 0.97 [12]) at a cost of $48,433 ($49,797 × 0.97); for CMS–10398 #24 (new quarterly report templates for ICF/IID and IMD) the burden is 31.2 hours (1,122 hr × 0.027 [13]) at a cost of $1,363 ($49,797 × 0.027).

(3) Utilization Reporting Template and Guidance Documents (§ 447.288(b)(2))

Annually, the proposed reporting of the specific amount of Medicaid payments made to each provider would include: (1) The total FFS base payments made to the provider authorized under the state plan; (2) the total Medicaid payments made to the provider under demonstration authority; (3) the total payment or funds received from Medicaid beneficiary cost-sharing requirements, donations, and any other funds received from third parties to support the provision of Medicaid services; (4) the total supplemental payment made to the provider authorized under the specified state plan; (5) the total Medicaid supplemental payment made to the provider under the specified demonstration authority, and the total Medicaid payments made to the provider as reported in the above areas; (6) the total DSH payments made to the provider; and (7) the Medicaid units of care (for example, on a provider-specific basis, total Medicaid discharges, days of care, or any other measures as specified by the Secretary).

A utilization report by provider service type would be required annually by states in this proposed rule, which includes all of the providers reported in the Supplemental Payments Reporting Templates (that is, all providers receiving supplemental payments), and reports all base payments, DSH payments, and additional utilization data from those providers. This Utilization Report includes all base payments made to each provider in the state, with the addition of DSH and Medicaid utilization data (23 data elements consisting of 9 demographic elements previously reported in the quarterly reports, 10 new elements specific to supplemental and other payments, and 4 new utilization elements).

The 9 demographic elements, linked to the same 8 elements in the quarterly reports plus 1 element stating the dates of the supplemental payment period, all covering the same providers in each service type, that received a supplemental payment under each authority listed in § 447.288(c)(1) including: (1) The provider's legal name; (2) the physical address of the location or facility where services are provided, including street address, city, state, and ZIP code; (3) the NPI; (4) the Medicaid identification number; (5) the EIN; (6) the service type for which the reported payment was made; (7) the provider specialty type (if applicable, for example, CAH, pediatric hospital, or teaching hospital); (8) the provider category (that is, state government, non-state government, or private); and (9) the state reporting period (state fiscal year start and end dates).

The 14 supplemental payment elements for Medicaid payments made to each provider consist of the following, as applicable: (1) The SPA transaction number or demonstration authority number which authorizes the supplemental payment; The specific amount of Medicaid payments made to each provider, including, as applicable; (2) the total FFS base payments made to the provider authorized under the state plan; (3) the total Medicaid payments made to the provider under demonstration authority; (4) the total payment or funds received from Medicaid beneficiary cost-sharing requirements; (5) the total payment or funds received from Medicaid donations; (6) the total of any other funds received from third parties to

[12] 97% of UPL providers receiving supplemental payments are IP, OP, and NF provider types.

[13] 2.7% of UPL providers receiving supplemental payments are ICF and IMD provider types.

support the provision of Medicaid services; (7) the total supplemental payment made to the provider authorized under the specified state plan; (8) the total Medicaid supplemental payment made to the provider under the specified demonstration authority; (9) the total Medicaid payments made to the provider as reported above (summation of 2–8 above); and (10) the total DSH payments made to the provider. The 4 utilization elements are comprised of: Up to four (11. through 14.) Medicaid unit of care metrics (for example, on a provider-specific basis, total Medicaid discharges, days of care, or any other measures as specified by the Secretary).

There are a total of 14 new data elements. The eight demographic elements and the SPA transaction number or demonstration authority number which authorizes the supplemental payment were reported during the previous quarterly CMS–64 reports submitted during the year, and therefore, are not counted in the collection of information here.

For the annual utilization report we estimate it would take 20 seconds at $32.44/hr for a data entry keyer to query states' MMIS system and/or copy and paste each data element into the required format for reporting. The burden associated with preparing and submitting the annual report consists of 571 hours (7,341 providers reported with supplemental payments in the UPL demonstration × 14 new data elements × 1 report/year × 20 seconds/3,600 seconds per hour) at a cost of $18,523 (571 hr × $32.44/hr).

Additionally, we estimate oversight by social science research assistants and general operations managers for the utilization annual report. We estimate it would take 1.5 hours at $48.48/hr for a social science research assistant and 1 hour at $119.12/hr for a general operations manager to review the report. In this regard we estimate an annual burden of 135 hours ([1.5 hr × 1 report × 54 states] + [1 hr × 1 report × 54 states]) at a cost of $10,359 ([1.5 hr × 1 report × 54 states × $48.48/hr] + [1 hr × 1 report × 54 states × $119.12/hr]).

Given the aforementioned burden estimates, we estimate a total of 706 hours (571 hr + 135 hr) at a cost of $28,882 ($18,522 + $10,359) for all information collection for the utilization report. Per state, this amounts to 13.1 hours (706 hrs/54 states) at a cost of $535 ($28,882/54 states).

Since the proposed requirements impact two information collection requests (CMS–10398 #13 and #24), we break down the cost to each, as above. The burden for CMS–10398 #13 is 687 hours (706 hr × 0.97) at a cost of $28,091 ($28,882 × 0.97). For CMS–10398 #24 the burden is 19.3 hours (706 hr × 0.027) at a cost of $791 ($28,882 × 0.027).

(4) Annual Non-Federal Share Reporting (§ 447.288(c)(3))

Section 447.288(c)(3), proposes to require that each state submit an annual report of the aggregate and provider-level information on each provider contributing to the state or any local unit of government any funds that are used as a source of the non-federal share for any Medicaid supplemental payment, including 17 data elements consisting of: 8 new demographic elements; 8 new supplemental and other payment elements; and 1 new summation element.

The 8 demographic elements of each provider that received a non-federal share for any Medicaid supplemental payment under each authority listed in § 447.288(a) include: (1) The service type for which the reported payment was made; (2) the provider specialty type (if applicable, for example, CAH, pediatric hospital, or teaching hospital) (3) the provider's legal name; (4) the physical address of the location or facility where services are provided, including street address, city, state, and ZIP code; (5) the NPI; (6) the Medicaid identification number; (7) the EIN; and (8) the provider category (that is, state government, non-state government, or private).

The 8 supplemental and other payment elements are comprised of: (1) The total FFS base payments made to the provider authorized under the state plan; (2) the total FFS supplemental payments made to the provider authorized under the state plan; (3) the total Medicaid payments made to the provider under demonstration authority; (4) the total DSH payments made to the provider; (5) the total of each health care-related tax collected from the provider by any state authority or local unit of government; (6) the total of any costs certified as a CPE by the provider; (7) the total amount contributed by the provider to the state or a unit of local government entity in the form of an IGT; and (8) the total of provider-related donations made by the provideror by entities related to a health care provider, including in-cash and in-kind donations, to the state or unit of local government, including state university teaching hospitals.

The summation element would require: (1) The total funds contributed by the provider (that is, CPEs, IGTs, provider taxes, donations, and any other funds contributed) as reported under the supplemental and other payment elements.

For the annual non-federal share report we estimate that all providers will contribute to the non-federal share. We believe this to be an overestimate, but this is the only estimate we have at this time using the UPL demonstration data that we have available. We also estimate that it would take 20 seconds at $32.44/hr for a data entry keyer to query states' MMIS system and/or copy and paste each of the 17 data elements into the required format for reporting. The burden associated with preparing and submitting the annual report consists of 2,666 hours (28,232 total providers × 17 data elements × 1 report/year × 20 seconds/3,600 seconds per hour) at a cost of $86,485 (2,666 hr × $32.44/hr).

Additionally, we estimate oversight by social science research assistants and general operations managers for the non-federal share annual report. We estimate it would take 4 hours at $48.48/hr for a social science research assistant and 2 hours at $119.12/hr for a general operations manager to review the report. In this regard we estimate an annual burden of 324 hours ([4 hr × 1 report × 54 states] + [2 hr × 1 report × 54 states]) at a cost of $23,337 ([4 hr × 1 report × 54 states × $48.48/hr] + [2 hr × 1 report × 54 states × $119.12/hr]).

Given the aforementioned burden estimates, we estimate a total of 2,990 hours (2,666 hr + 324 hr) at a cost of $109,833 ($86,497 + $23,337) for all information collection requests for the non-federal share report. Per state, this amounts to 55.4 hours (2,990 hr/54 states) at a cost of $2,034 ($109,833/54 states).

Since the proposed requirements impact two information collection requests (CMS–10398 #13 and #24), the burden for CMS–10398 #13 is 2,617 hours (2,990 hr × 0.875 [14]) at a cost of $94,427 ($109,833 × 0.875). For CMS–10398 #24 the burden is 373.5 hours (2,990 hr × 0.125 [15]) at a cost of $13,717 ($109,833 × 0.13).

4. ICRs Regarding DSH Reporting Requirements (§ 447.299)

The following proposed changes will be submitted to OMB for approval under control number 0938–0746 (CMS–R–266). Subject to renewal, the control number is currently set to expire on April 30, 2022. It was last approved on April 9, 2019, and remains active.

Under § 447.299 this proposed rule would require states to provide an

[14] 87.5% of all UPL providers reported are IP, OP, and NF provider types.

[15] 12.5% of all UPL providers reported are ICF & IMD.

additional data element as part of its annual DSH audit report. This additional element would require a state auditor to quantify the financial impact of any audit finding not captured within any other data element under § 447.299(c), which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit.

If the auditor is unable to determine the actual financial impact amount of an audit finding, the auditor would be required to provide a statement of the estimated financial impact for each audit finding identified in the independent certified audit.

The proposed additional data element requires auditors to indicate the financial impact of all findings rather than indicating that the financial impact of any finding is unknown. We believe the additional burden associated with the new data element would be minimal given that auditors are already engaged in a focused review of available documentation to quantify the aggregate amounts that comprise each of the existing data elements required under § 447.299(c).

The burden consists of the time it would take each of the states to quantify any audit finding identified during the independent certified audit required under section 1923(j)(2) of the Act. The territories have been excluded from this proposed requirement since they do not receive a DSH allotment under section 1923(f) of the Act.

To estimate the overall burden of adding this new data element to the reporting requirement, we considered the number of annual independent certified audits received by CMS in addition to the number of unquantified audit findings.

This rule would require the submission of data in an electronic spreadsheet format that would take approximately 2 hours, consisting of: 1 hour at $111.14/hr for management and professional staff to review the report and 1 hour at $74.60/hr for a financial specialist to prepare the report. In aggregate we estimate an ongoing annual burden of 102 hours (51 states × 2 hr/response × 1 response/year) at a cost of $9,473 ((51 states × [(1 hr $111.14/hr) + (1 hr × $74.60/hr)] or $186 per state ($9,473/51 states). Additionaly we anticipate that a state auditor would have to spend an additional hour quantifying the financial impact of DSH findings that are classified as unknown. The estimated annual burden would be 1 hour per state (51 states × 1 hour) 51 hours × 75.78/hr for auditors to complete the audit at a cost of $3,865 per year (51 states × 1 hour × $75.78 per hour). The total cost of this proposed rule would be $13,338 ($9,473 + $3,865) and 153 hours or $262 per state and 3 hours per state.

C. Summary of Annual Burden Estimates for Proposed Requirements

Table 3 summarizes the burden for the aforementioned proposed provisions

TABLE 3—PROPOSED ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS

Regulation section(s) under title 42 of the CFR	OMB control No. (CMS ID No.)	Respondents	Responses (per state)	Total responses	Burden per response (hours)	Total annual burden (hours)	Labor costs of reporting	Total cost ($)
§ 443.72 tax waiver	0938–0618 (CMS–R–148).	51	0.4	20	2	40	37.60	1,504
§§ 447.252 and 447.302	0938–0193 (CMS–179) ..	54	1.9	126	0.5	63.2	48.48	3,064
§ 447.288 UPL demo. (IP, OP, NF).	0938–1148 (CMS–10398 #13).	5	−5	−10	8	−80	varies	−3,057
§ 447.288 UPL demo. (ICF, IMD).	0938–1148 (CMS–10398 #24).	5/51	−5/−3	−10/−162	8/8	−80/−1296	varies	−3,057/−49,528
§ 447.288 SP quarterly reports (IP, OP, NF).	0938–1148 (CMS–10398 #13).	54	20	1,080	varies	1108	varies	48,433
§ 447.288 SP quarterly reports (ICF, IMD).	0938–1148 (CMS–10398 #24).	54	20	1,080	varies	31	varies	1,363
§ 447.288 Utilization annual report (IP, OP, NF).	0938–1148 (CMS–10398 #13).	54	14	756	varies	687	varies	28,091
§ 447.288 Utilization annual report (ICF, IMD).	0938–1148 (CMS–10398 #24).	54	14	756	varies	19	varies	791
§ 447.288 Non-federal share annual report (IP, OP, NF).	0938–1148 (CMS–10398 #13).	54	17	918	varies	2,617	varies	94,427
§ 447.288 Non-federal share annual report (ICF, IMD).	0938–1148 (CMS–10398 #24).	54	17	918	varies	374	varies	13,717
§ 447.299 DSH audit	0938–0746 (CMS–R–266).	51	1	51	3	153	varies	13,338
Total	.....	varies	95	5,787	varies	3,637	varies	145,221

For all parts of this proposed rule, we estimate there would be a total nationwide burden of 3,637 hours at a cost of $145,221 and an average of 67 hours (3,637 hr/54 states) at a cost of $2,847 per state Medicaid agency per year ($145,221/54 states).

D. Requirements Not Subject to the PRA

The following regulatory sections propose changes to definitions, policy guidance, and clarifications of existing statutes or regulatory provisions. The changes do not have any collection of information implications, and therefore, are not subject to the requirements of the PRA: §§ 430.42 (Disallowance of claims for FFP), 433.51 (State share of financial participation), 433.52 (General definitions), 433.54 (Bona fide donations), 433.55 (Health care-related taxes defined), 433.56 (Classes of health care services and providers defined), 433.68 (Permissible health care-related taxes), 433.72 (Waiver provisions applicable to health care-related taxes), 433.316 (When Discovery of Overpayment occurs and its Significance), 447.201 (State plan requirements), 447.207 (Retention of payments), 447.272 (Inpatient services: Application of UPLs), 447.284 (Basis and purpose), 447.286 (Definitions), 447.290 (Failure to Report Required Information), 447.297 (Limitations on aggregate payments for DSHs beginning October 1, 1992), 447.321 (Outpatient hospital services: Application of UPLs), 455.301 (Definitions), 455.304 (Condition for FFP), and 457.609

(Process and calculation of state allotments for a fiscal year after FY 2008).

E. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's ICRs. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit the CMS website at *www.cms.hhs.gov/PaperworkReductionActof1995,* or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential ICRs. If you wish to comment, please submit your comments electronically as specified in the **DATES** and **ADDRESSES** section of this proposed rule and identify the rule (CMS–2393–P) the ICR's CFR citation, and OMB control number.

V. Regulatory Impact Analysis

A. Statement of Need

This proposed rule would impact states' reporting on payment methods and procedures to assure consistency with efficiency, economy, and quality of care as required by section 1902(a)(30)(A) of the Act. CMS, and other federal oversight entities, have found that current regulations and guidance do not adequately assure that states are complying with the efficiency, economy and quality of care requirements of section 1902(a)(30)(A) of the Act, and this rule is intended to address those deficiencies. We view this proposed rule as one approach to add additional accountability and transparency for Medicaid payments, and to provide CMS with certain information on supplemental payments to Medicaid providers, including supplemental payments approved under either Medicaid state plan or demonstration authority, establish new state plan requirements for amendments proposing supplemental payments, and otherwise ensure the proper and efficient operation of the Medicaid state plan. This proposed rule would address the funding of these supplemental and other Medicaid payments through states' uses of health care-related taxes and bona fide provider-related donations.

Medicaid DSH payments and requirements are addressed in this proposed rule. We propose to add additional specificity to the reporting requirements of the annual DSH audit conducted by an independent auditor to enhance federal oversight of the Medicaid DSH program. Additionally, we seek to improve the accurate identification of and collection efforts related to overpayments identified through the annual DSH independent certified audits by specifying the date of discovery and standards for redistribution of DSH payments made to providers in excess of the hospital-specific limit.

The proposed rule also seeks to alleviate the administrative burden of publishing the annual DSH and CHIP allotments in the **Federal Register**, of which we simultaneously notify states directly by providing notification through other, more practical means. Finally, we propose changes to the disallowance reconsideration procedures in order to modernize the process by relying on an electronic, rather than a hard-copy paper process.

B. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of beneficiaries thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

We estimate these provisions to meet the criteria for economic significance based upon the analysis of certain provisions in the proposed rule, as discussed in more detail below. The proposed reporting requirements largely contain data already available to states in their own fiscal management and claims processing systems, and merely requires states to report the data to us. Additional information on setting goals for supplemental payments and evaluating the positive and negative aspects of these goals over time, while these requirements are consistent and necessary to ensure compliance with section 1902(a)(30)(A) of the Act, which requires payments be consistent with efficiency, economy, and quality of care, they will require state Medicaid programs to develop and consider various compliance options. Moreover, the reporting requirements and supplemental payment evaluations are generally consistent with current state oversight and review activities of each state's Medicaid program, and states have the flexibility within their reviews to use their existing data or build upon that data when reviewing supplemental payments to providers, in order to formulate goals and evaluate the effectiveness of these payments. In fact, the policies in this proposed rule are intended to focus on state efforts in monitoring and overseeing data and methodologies concerning supplemental and other payments as well as sources of non-federal share to enhance states' ability to comply with section 1902(a)(30)(A) of the Act and our ability to ensure such compliance.

C. Anticipated Effects

1. Effects of Reporting Requirements on State Medicaid Programs

For all parts of this proposed rule we estimate there would be a total nationwide burden of 3,637 hours at a cost of $145,221 and an average of 67 hours (3,637 hr/54 states) at a cost of $2,847 per state Medicaid agency per year ($145,221/54 states) per state and District of Columbia Medicaid agency per year (see section IV. of this proposed rule, Collection of Information Requirements, for details on this cost assessment and a breakdown of the burden from the various parts of this proposed rule).

The proposed rule adds several reporting requirements, including:

§§ 447.252 and 447.302, which would add goals, evaluations, and 3-year renewable authorizations on any supplemental payment methodology, providing a transition schedule for SPAs to be updated. Section 447.288, would add 4 quarterly reports with data on expenditures claimed for each supplemental payment made under state plan or demonstration authority by provider, and an annual report with 2 sections—one section with a roll up of the quarterly data with added Medicaid utilization measures and one section with information on all providers contributing to the state or any other governmental entity any portion of the non-federal share of the supplemental payment and the total of their contributions.

This regulation codifies states reporting annual UPL demonstrations that CMS discussed in an SMDL issued on March 18, 2013 (SMDL #13–003) regarding annual submission of Medicaid UPLs. In this proposed rule, § 447.288(a) would decrease burden by eliminating the UPL demonstrations for three service types—PRTF, clinic services, and other inpatient & outpatient facility providers (physician services), note that the UPL demonstrations for the territories the Commonwealth of the Northern Mariana Islands (CNMI) and American Samoa are excluded from this estimate because they provide Medicaid services under section 1902(j) waivers. This OMB approved UPL demonstration (OMB Control Number: 0938–1148, CMS–10398 (#13) (#24)) will be updated accordingly.

For § 447.206 on Payments funded by CPEs made to providers that are units of government, states would be required to develop processes that are already used by CMS and routinely asked of states to comply with section 1902(a)(30)(A) of the Act that requires Medicaid state plan methods and procedures relating to the payment for services that are consistent with efficiency, economy, and quality of care. These collections of information are already routinely asked of states under existing OMB control numbers, so no additional burden or economic impact is anticipated.

2. Effects on Small Businesses and Other Providers

This rule establishes requirements that are solely the responsibility of state Medicaid agencies, which are not small entities. Therefore, the Secretary certifies this proposed rule would not, if promulgated, have a significant economic impact on a substantial number of small entities.

3. Effects on the Medicaid Program

The fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown. The provision that would have the most direct impact on current provider payments is the Medicaid practitioner supplemental payment requirements proposed in § 447.406. To summarize, this provision would limit Medicaid practitioner base plus supplemental payments to 150 percent of the FFS base payments authorized under the state plan for the practitioner services within a defined geographic area that would otherwise be paid to the targeted practitioners, or for services provided within HRSA-designated geographic HPSA or Medicare-defined rural geographical areas, Medicaid practitioner base plus supplemental payments may not exceed 175 percent of the FFS base payments authorized under the state plan for the practitioner services within a defined geographic area that would otherwise be paid to the targeted practitioners.

To analyze the impact of this proposed change, CMS reviewed the 2017 Medicaid physician UPL demonstrations which were submitted by states that make supplemental payments to physicians and other practitioners. In 2017, 21 states made approximately $478 million in physician supplemental payments compared with $512 million in Medicaid FFS base payments to the practitioners eligible to receive the supplemental payments, which equals $990 million in total payments for the qualifying providers that received a supplemental payment. To measure the impact, we would multiply the total Medicaid FFS base payments ($512 million) by 150 percent which would equal $768 million in total Medicaid FFS payments with the net Medicaid physician supplemental payment amount of $256 million. The estimated impact of this proposed provision is a reduction in payments of $222 million in total computable Medicaid reimbursement ($478 million minus $256 million equals $222 million). However, this potential decrease in Medicaid reimbursements could be mitigated if states take action to increase Medicaid provider base payments, which would thereby increase the amount that could be paid out in Medicaid practitioner supplemental payments. Depending on state action in response to this provision, we estimate that the impact on Medicaid reimbursements could range from $0 to $222 million. Similarly, we do not have sufficient data to predict or quantify the impact of the proposed provisions on health-care related taxes, although we would expect that states may modify existing state tax policy or arrangements where those taxes or arrangements would be newly be considered health-care related under the proposed provisions. We invite comments from states, providers, and other stakeholders on the estimates and potential state responses to these provisions. There are some considerations that limit the effect of the proposed change. First, the proposed rule phases out these supplemental payments over a 5 to 7-year period based on when the supplemental payment was last approved. The supplemental payments, as currently approved in the plan, would begin to be incrementally removed from the state plan after the provision is finalized. Second, Medicaid practitioner supplemental payments would only be limited by the amount of the Medicaid FFS base payments. If a state wanted to increase the amount of the supplemental payment, the state would have the option under the proposed rule to increase the base payment that is paid to all providers within a geographic area of the state and thereby also increase what the state could pay in supplemental payments to targeted providers under the state plan. Third, in almost all instances, the providers were supplying the state with the non-federal share of the Medicaid practitioner supplemental payments. Without the supplemental payments, it is likely that the arrangements through which the providers have been transferring the state share to the state Medicaid agency to support current high levels of Medicaid practitioner supplemental payments would cease, and therefore, the net impact on the providers would be far less than the projected amount of decrease in practitioner supplemental payments. Finally, the projected impact does not include any consideration for Medicaid physician base plus supplemental payments that could be paid under the proposal in HRSA-designated geographic HPSA or in Medicare's rural geographic areas up to 175 percent of the Medicaid FFS base payment rate. If any of the providers included in the state's physician UPL demonstrations are in those areas, the net impact of the proposed change would be reduced.

We would also point out that the data obtained from the quarterly and annual reports would support the evaluation of varying payment streams impacting providers' services and quality and would allow for greater oversight on supplemental payments, including

payments that could exceed the UPL; DSH payments; and generally provide better fiduciary oversight of the Medicaid program.

D. Alternatives Considered

In developing this proposed rule, the following alternatives were considered:

1. Not Proposing the Rule

We considered not proposing this rule and maintaining the status quo. However, we believe this proposed rule would lead to better accountability and transparency for supplemental payments. We do not currently have the necessary data at the state and provider level to perform adequate analysis and oversight of supplemental payments, and this proposed rule would allow us to do so.

2. Eliminating Supplemental Payments

We considered proposing a rule that would eliminate supplemental payments. However, this option could have been a huge burden on states to revise payment methodologies, cost reports, and fee schedules. Also, this option would have eliminated an important avenue for states potentially to reward providers that show improvement in performance or quality metrics, and to address urgent access problems that may arise. At this time, we believe our concerns about accountability and transparency around supplemental payments may be addressed through the proposed policies and do not require the draconian step of eliminating state flexibility by prohibiting such payments altogether.

3. Requiring Equal Distribution of Supplemental Payments

We considered proposing to require equal distribution of supplemental payments to all providers of the relevant class of services. This option would have eliminated states' ability to target supplemental payments to one or a small number of providers, and thus could have more closely linked supplemental payments to services provided. However, we opted to not propose this provision at this time as this proposal would have increased burden on state Medicaid agencies by requiring revision of payment methodologies and tracking supplemental payments for all providers of services within the relevant class.

4. Requiring DSH-Like Audits of Supplemental Payments

We considered proposing to require independent certified audits of all Medicaid supplemental payments, similar to the audit requirement for all DSH payments. Under this alternative, for states to receive FFP for supplemental payments, an independent certified audit would be required to verify that all supplemental payments were appropriate. However, we decided not to propose this alternative at this time, due to the need for more and better data to understand the complex nature of supplemental payments so that we may better understand the particular audit structure and requirements needed to effectively monitor supplemental payment programs.

5. Mandating a Provider-Specific UPL

We considered proposing a provider-specific UPL for certain services. However, imposing such a provision at this time could have disrupted current public financing methods and would also have imposed a burden on states to revise longstanding payment methodologies.

6. Setting 5-Year Renewable Authorizations for Supplemental Payments and a 5-Year Compliance Transition Period

Another alternative we considered was to propose 5-year renewable authorizations for supplemental payments, instead of the proposed 3-year renewable authorizations. The 5-year renewal period for supplemental payments would have decreased administrative burden on both the states and federal government, as opposed to the 3-year renewal period, as we would expect to see less frequent SPA re-submissions and CMS SPA reviews, respectively; in our judgment, the effort spent on reviewing, evaluating, and working with states to improve supplemental payment SPAs is a worthwhile effort toward the end of more fiscal accountability in the Medicaid program. Also, the 3-year renewal period is consistent with the 3-year approval period for health-care related tax waivers proposed in § 433.72 of this proposed rule.

We also considered proposing a 5-year compliance transition period instead of the proposed 3-year compliance transition period in §§ 447.252(e) and 447.302(d). This would have increased the amount of time states would have to bring existing, approved supplemental payment methodologies into compliance with the provisions of the proposed rule in these two sections. We decided to propose a 3-year transition period to account for states where changes may require legislative action as some legislatures meet on a biennial basis, and therefore, would make compliance with a 3-year transition period compatible. We are requesting comment on whether or not to pursue an expanded transition period of 5 years instead of the proposed 3-year transition period.

7. Setting 5-Year or 1-Year Deadline for Tax Waiver Renewals

We considered proposing 5 years, or 1 year, as the length of the approval period for tax waivers before states would need to submit another request. However, we settled on 3 years because we believe that it would help ensure fiscal accountability and the fiscal integrity of the Medicaid program by ensuring that provider data for the classes to be taxed is up to date, while at the same time avoiding undue regulatory burden on states.

8. Requiring Both the P1/P2 and the B1/B2 Tests for Non-Uniform Health Care-Related Taxes

In evaluating how to eliminate tax structures that are problematic because they place an undue burden on the Medicaid program, we considered requiring the P1/P2 statistical test in § 433.68(e)(1) in addition to the B1/B2 statistical test in § 433.68(e)(2), for states requesting a waiver of the uniformity requirement (whether or not the state is also requesting a waiver of the broad-based requirement). Under this alternative, a state that requests a waiver of the uniformity requirement would need to have its tax pass both the P1/P2 test in addition to the B1/B2 test currently required. We believe that this statistical test could serve as a broad tool to prohibit tax structures that would inappropriately burden the Medicaid program in ways not explicitly prohibited in current regulation. However, we decided against this approach to balance preserving an appropriate degree of flexibility for states in designing tax programs with ensuring that state taxes are not imposed primarily on Medicaid providers and services. We believe that the categorical prohibitions against tax structures that unduly burden Medicaid which we are proposing to add in § 433.68(e)(3) offer sufficient protection to the financial health of the title XIX program.

In addition, we considered proposing a list of acceptable commonalities that states could permissibly use to define taxpayer groups. However, we believe that this could be overly restrictive to states and impede their flexibility to structure their tax programs in ways that suit local circumstances while still complying with all applicable federal requirements. We are soliciting comment on additional prohibitions

against unduly burdening the Medicaid program that might also be added to this section to avoid such arrangements.

9. Audit Requirement To Quantify Financial Impact of Audit Findings

We considered proposing to require auditors to clarify the impact of audit findings and caveats within the existing data element report by incorporating finding amounts into existing data elements (for example, Total Medicaid Uncompensated Care). However, this option may not enable auditors to effectively capture financial impacts of specific issues and such finding might not be readily transparent to states, CMS, and hospitals; therefore, we opted to include this as an additional data element on the DSH report.

10. Clarifying the Discovery Date for DSH Overpayments and Redistribution Requirements

We considered proposing to use the date that the auditor submits the independent certified audit to the state as the date of discovery for DSH overpayments identified through the independent certified audit, but ultimately decided to consider the date that a state submits the independent certified audit to CMS as the discovery date. The earlier date would start the clock for state repayment of FFP without regard to possible work that may need to occur between states and auditors to finalize the audit and associated reporting prior to submission to CMS.

11. Technical Changes to Publishing DSH and CHIP Allotments

We considered continuing the requirement to publish the DSH and CHIP allotments in the **Federal Register**. However, we believe this is unnecessary as states are already informed regarding their annual DSH and CHIP allotments prior to the publication of the **Federal Register** notice that we now provide and, in our experience, we have not received public comment regarding the notice.

12. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars_a004_a-4*), we have prepared an accounting statement in Table 1 showing the classifaction of the transfers associated with the provisions of this proposed rule.

TABLE 1—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS

[$ In millions]

Category	Lower bound	Upper bound	Units		
			Year dollars	Discount rate (%)	Period covered
Transfers					
Annualized Monetized reductions in Costs	0	−222	2017	7	2020
	0	−222	2017	3	2020
From Whom to Whom	Medicaid to Medicaid Providers.				

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $8.0 million to $41.5 million in any one year). Individuals and states are not included in the definition of a small entity. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the provisions in this proposed rule.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately $150 million. This rule does not contain mandates that will impose spending costs on state, local, or tribal governments in the aggregate, or by the private sector, in excess of the threshold.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This rule does not impose substantial direct costs on state or local governments or preempt state law.

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017, requires that the costs associated with significant new regulations ''to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' This rule, if promulgated, is not expected to be subject to the requirements of E.O. 13771 because it is expected to result in no more than de minimis costs.

E. Conclusion

If the policies in this proposed rule are finalized, states would be required to send us more detailed data on payments, including supplemental and DSH payments, Medicaid utilization data, provider taxes and donations, and CPEs and IGTs; implement new reviews of supplemental payment methodologies and tax waivers and periodically seek authorization for their renewal (if desired by the state); and provide a narrative to be sent in along

with supplemental payment SPA submissions on the goals and evaluation of the payments.

In addition, states would also be allowed to tax services of health insurers excluding services of MCOs, as a permitted class without experiencing a reduction in medical assistance expenditures, be prohibited from unduly burdening Medicaid with taxes that are not generally redistributive, and be required to renew tax waivers every 3 years, with updated provider data, or sooner if the state changes the definitions of taxpayer groups or tax rates in a non-uniform manner.

The analysis above, together with the remainder of this preamble, provides a regulatory impact analysis. In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 430

Administrative practice and procedure, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs-health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 455

Fraud, Grant programs—health, Health facilities, Health professions, Investigations, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 430—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

■ 1. The authority citation for part 430 is revised to read as follows:

Authority: 42 U.S.C. 1302.

■ 2. Section 430.42 is amended by revising paragraphs (b)(2)(i)(A) introductory text, (b)(2)(i)(B) and (C), (c)(3), (c)(4)(i), (c)(6), and (d)(1) to read as follows:

§ 430.42 Disallowance of claims for FFP.

* * * * *

(b) * * *

(2) * * *

(i) * * *

(A) A request to the Administrator that includes the following:

* * * * *

(B) A copy of the request to the Regional Office.

(C) Send all requests for reconsideration via electronic mail (email) or electronic system specified by the Administrator. Submissions are considered made on the date they are received by the Administrator via email or electronic system specified by the Administrator.

* * * * *

(c) * * *

(3) At the Administrator's option, CMS may request from the State any additional information or documents necessary to make a decision. The request for additional information must be sent via email or electronic system specified by the Administrator. Submissions are considered made on the date they are received by the Administrator via email or electronic system specified by the Administrator.

(4) * * *

(i) If the Administrator finds that the materials are not in readily reviewable form or that additional information is needed, he or she must notify the State via email or electronic system specified by the Administrator that it has 15 business days from the date of receipt of the notice to submit the readily reviewable or additional materials. Notifications are considered made and received on the date they are sent by the Administrator via email or electronic system specified by the Administrator.

* * * * *

(6) The final written decision shall constitute final CMS administrative action on the reconsideration and shall be (within 15 business days of the decision) sent to the State agency via email or electronic system specified by the Secretary. Notification is considered made on the date it is sent by the Administrator via email or electronic system specified by the Administrator.

* * * * *

(d) * * *

(1) A State may withdraw the request for reconsideration at any time before the notice of the reconsideration decision is made without affecting its right to submit a notice of appeal to the Board. The request for withdrawal must be in writing and sent to the Administrator, with a copy to the Regional Office, via email or electronic system specified by the Administrator. Notification of the State's withdrawal of its request for reconsideration is considered made on the date it is received by the Administrator via email or electronic system specified by the Administrator.

* * * * *

PART 433—STATE FISCAL ADMINISTRATION

■ 3. The authority citation for part 433 is revised to read as follows:

Authority: 42 U.S.C. 1302.

■ 4. Section 433.51 is revised to read as follows:

§ 433.51 State share of financial participation.

(a) State or local funds may be considered as the State's share in claiming Federal financial participation (FFP) if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) State or local funds that may be considered as the State's share are any of the following:

(1) State General Fund dollars appropriated by the State legislature directly to the State or local Medicaid agency.

(2) Intergovernmental transfer of funds from units of government within a State (including Indian tribes), derived from State or local taxes (or funds appropriated to State university teaching hospitals), to the State Medicaid Agency and under its administrative control, except as provided in paragraph (d) of this section.

(3) Certified Public Expenditures, which are certified by a unit of government within a State as representing expenditures eligible for FFP under this section, and which meet the requirements of § 447.206 of this chapter.

(c) The State or local funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

(d) State funds that are provided as an intergovernmental transfer from a unit of government within a State that are contingent upon the receipt of funds by, or are actually replaced in the accounts of, the transferring unit of government from funds from unallowable sources, would be considered to be a provider-related donation that is non-bona fide under §§ 433.52 and 433.54.

■ 5. Section 433.52 is amended—

■ a. By adding the definitions of ''Medicaid activity'', ''Net effect'', ''Non-Medicaid activity'', and ''Parameters of a tax'' in alphabetical order;
■ b. In the definition of ''Provider-related donation'' by revising paragraphs (2) and (3) and adding paragraph (4); and
■ c. By adding the definition of ''Taxpayer group'' in alphabetical order.

The additions and revision read as follows:

§ 433.52 General definitions.

* * * * *

Medicaid activity means any measure of the degree or amount of health care items or services related to the Medicaid program or utilized by Medicaid beneficiaries. Such a measure could include, but would not necessarily be limited to, Medicaid patient bed days, the percentage of an entity's net patient revenue attributable to Medicaid, Medicaid utilization, units of medical equipment sold to individuals utilizing Medicaid to pay for or supply such equipment or Medicaid member months covered by a health plan.

Net effect means the overall impact of an arrangement, considering the actions of all of the entities participating in the arrangement, including all relevant financial transactions or transfers of value, in cash or in kind, among participating entities. The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities, and may include consideration of reciprocal actions without regard to whether the arrangement or a component of the arrangement is reduced to writing or is legally enforceable by any entity.

Non-Medicaid activity means the degree or amount of health care items or services not related to the Medicaid program or utilized by Medicaid beneficiaries. Such a measure could include, but would not necessarily be limited to, non-Medicaid patient bed days, percentage of an entity's net patient revenue not attributable to Medicaid, the percentage of patients not utilizing Medicaid to pay for health care items or services, units of medical equipment sold to individuals not utilizing Medicaid funds to pay for or supply such equipment, or non-Medicaid member months covered by a health plan.

Parameters of a tax means the grouping of individuals, entities, items or services, on which the State or unit of government imposes a tax.

Provider-related donation * * *

(2) Any transfer of value where a health care provider or provider-related entity assumes an obligation previously held by a governmental entity and the governmental entity does not compensate the private entity at fair market value will be considered a donation made indirectly to the governmental entity. Such an assumption of obligation need not rise to the level of a legally enforceable obligation to be considered a donation, but will be considered by examining the totality of the circumstances and judging the arrangement's net effect.

(3) When an organization receives less than 25 percent of its revenues from providers and/or provider-related entities, its donations will not generally be presumed to be provider-related donations. Under these circumstances, a provider-related donation to an organization will not be considered a donation made indirectly to the State. However, if the donations from a provider or entities related to a provider to an organization are subsequently determined to be indirect donations to the State or unit of local government for administration of the State's Medicaid program, then such donations will be considered to be provider-related donations.

(4) When the organization receives more than 25 percent of its revenue from donations from providers or provider-related entities, the organization always will be considered as acting on behalf of health care providers if it makes a donation to the State. The amount of the organization's donation to the State, in a State fiscal year, that will be considered to be a provider-related donation will be based on the percentage of the organization's revenue during that period that was received as donations from providers or provider-related entities.

Taxpayer group means one or more entities grouped together based on one or more common characteristics for purposes of imposing a tax on a class of items or services specified under § 433.56.

■ 6. Section 433.54 is amended by revising paragraph (c)(3) to read as follows:

§ 433.54 Bona fide donations.

* * * * *

(c) * * *

(3) The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver, such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other party or parties responsible for the donation). Such a guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the State (or other unit of government) and the provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or a related entity will receive a return of all or a portion of the donation. The net effect of such an arrangement may result in the return of all or a portion of the donation, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.

* * * * *

■ 7. Section 433.55 is amended by revising paragraph (c) to read as follows:

§ 433.55 Health care-related taxes defined.

* * * * *

(c) A tax is considered to be health care-related if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to individuals or entities that are providers or payers of any health care items or services that are not subject to the tax, or other individuals or entities that are subject to the tax. In determining whether differential treatment exists, consideration will be given to the parameters of the tax, as well as the totality of the circumstances relevant to which individuals, entities, items, or services are subject and not subject to the tax, and the tax rate applicable to each. Differential treatment includes, but is not limited to:

(1) Tax programs in which some individuals or entities providing or paying for health care items or services are selectively incorporated, but others are excluded. Selective incorporation means that the State or other unit of government includes some, but not all, health care-related items or services and these items or services are not reasonably related to the other items or services being taxed. Reasonably related means that there exists a logical or thematic connection between the items or services being taxed. Examples of such a connection include, but are not limited to, industry, such as electronics; geographical area, such as city or county; net revenue volume; or number of employees. For example, if the State imposes a tax on all telecommunication services and inpatient hospital services, this would constitute differential treatment as inpatient hospital services are selectively incorporated. However, if the State imposes a tax on revenue from

all professional services, which includes medical professional service revenue, this alone would not constitute differential treatment.

(2) Differential treatment of individuals or entities providing or paying for health care items or services included in the tax, and other entities also included in the tax. For example, if the State taxes all businesses in the State, but places a higher tax rate on hospitals and nursing facilities than on other businesses, this would result in differential treatment.

* * * * *

■ 8. Section 433.56 is amended—

■ a. In paragraph (a)(18), removing the phrase ''services; and'' and adding in its place the phrase ''services;'';

■ b. Redesignating paragraph (a)(19) as paragraph (a)(20); and

■ c. Adding a new paragraph (a)(19).

The addition reads as follows:

§ 433.56 Classes of health care services and providers defined.

(a) * * *

(19) Services of health insurers (other than services of managed care organizations as specified in paragraph (a)(8) of this section); and

* * * * *

■ 9. Section 433.68 is amended by—

■ a. Revising paragraph (e) introductory text;

■ b. Adding paragraph (e)(3); and

■ c. Revising paragraph (f)(3).

The revisions and addition read as follows:

§ 433.68 Permissible health care-related taxes.

* * * * *

(e) *Generally redistributive.* A tax will be considered to be generally redistributive if it meets the requirements of this paragraph (e). If the State requests waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraphs (e)(1) and (3) of this section. If the State requests waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraphs (e)(2) and (3) of this section.

* * * * *

(3) *Requirement to avoid imposing undue burden on health care items or services reimbursed by Medicaid, as well as providers of such items or services.* This paragraph (e)(3) applies on a per class basis. A tax must not impose undue burden on health care items or services paid for by Medicaid or on providers of such items and services that are reimbursed by Medicaid. A tax is considered to impose undue burden under this paragraph if taxpayers are divided into taxpayer groups and any one or more of the following conditions apply:

(i) The tax excludes or places a lower tax rate on any taxpayer group defined by its level of Medicaid activity than on any other taxpayer group defined by its relatively higher level of Medicaid activity.

(ii) Within each taxpayer group, the tax rate imposed on any Medicaid activity is higher than the tax rate imposed on any non-Medicaid activity (except as a result of excluding from taxation Medicare or Medicaid revenue or payments as described in paragraph (d) of this section).

(iii) The tax excludes or imposes a lower tax rate on a taxpayer group with no Medicaid activity than on any other taxpayer group, unless all entities in the taxpayer group with no Medicaid activity meet at least one of the following:

(A) Furnish no services within the class in the State.

(B) Do not charge any payer for services within the class.

(C) Are Federal provider of services within the meaning of § 411.6 of this chapter.

(D) Are a unit of government.

(iv) The tax excludes or imposes a lower tax rate on a taxpayer group defined based on any commonality that, considering the totality of the circumstances, CMS reasonably determines to be used as a proxy for the taxpayer group having no Medicaid activity or relatively lower Medicaid activity than any other taxpayer group.

(f) * * *

(3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount. A direct guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the State (or other unit of government) and the taxpayer results in a reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount. The net effect of such an arrangement may result in the return of all or any portion of the tax amount, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.

■ 10. Section 433.72 is amended by adding paragraphs (c)(3) and (4) and (d) to read as follows:

§ 433.72 Waiver provisions applicable to health care-related taxes.

* * * * *

(c) * * *

(3) For waivers approved on or after [final rule effective date] a waiver will cease being effective 3 years from the date that the waiver was approved by CMS.

(4) For waivers approved before [final rule effective date] a waiver will cease to be effective [3 years from final rule effective date].

(d) *Ongoing compliance with waiver conditions.* For a State to continue to receive tax revenue (within specified limitations) without a reduction in FFP under a waiver approved under paragraph (b) of this section, the State must meet all of the following requirements:

(1) Ensure that the tax program for which CMS approved the waiver under paragraph (b) of this section continues to meet the waiver conditions identified in paragraphs (b)(1) through (3) of this section at all times during which the waiver is in effect.

(2) Request and receive approval for a new waiver, subject to effective date requirements in paragraph (c) of this section, if either of the following tax program modifications occurs:

(i) The State or other unit of government imposing the tax modifies the tax in a non-uniform manner, meaning the change in tax or tax rate does not apply in an equal dollar amount or percentage change to all taxpayers.

(ii) The State or other unit of government imposing the tax modifies the criteria for defining the taxpayer group or groups subject to the tax.

■ 11. Section 433.316 is amended by—

■ a. Redesignating paragraphs (f) through (h) as paragraphs (g) through (i), respectively; and

■ b. Adding a new paragraph (f).

The addition reads as follows:

§ 433.316 When discovery of overpayment occurs and its significance.

* * * * *

(f) *Overpayments identified through the disproportionate share hospital (DSH) independent certified audit.* In the case of an overpayment identified through the independent certified audit required under part 455, subpart D, of this chapter, CMS will consider the overpayment as discovered on the earliest of the following:

(1) The date that the State submits the independent certified audit report required under § 455.304(b) of this chapter to CMS.

(2) Any of the dates specified in paragraphs (c)(1) through (3) of this section.

* * * * *

PART 447—PAYMENTS FOR SERVICES

■ 12. The authority citation for part 447 is revised to read as follows:

Authority: 42 U.S.C. 1302 and 1396r–8.

■ 13. Section 447.201 is amended by adding paragraph (c) to read as follows:

§ 447.201 State plan requirements.

* * * * *

(c) The plan must provide for no variation in fee-for-service payment for a Medicaid service on the basis of a beneficiary's Medicaid eligibility category, enrollment under a waiver or demonstration project, or FMAP rate available for services provided to an individual in the beneficiary's eligibility category.

■ 14. Section 447.206 is added to subpart B to read as follows:

§ 447.206 Payments funded by certified public expenditures made to providers that are units of government.

(a) *Scope.* This section applies only to payments made to providers that are State government providers or non-State government providers, as defined in § 447.286, where such payments to such providers are funded by a certified public expenditure, as specified in § 433.51(b)(3) of this chapter.

(b) *General rules.* (1) Payments are limited to reimbursement not in excess of the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries using reasonable cost allocation methods as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, to Medicare cost principles specified in part 413 of this chapter.

(2) The State must establish and implement documentation and audit protocols, which must include an annual cost report to be submitted by the State government provider or non-State government provider to the State agency that documents the provider's costs incurred in furnishing services to beneficiaries during the provider's fiscal year.

(3) Only the certified amount of the expenditure may be claimed for Federal financial participation.

(4) The certifying entity of the certified public expenditure must receive and retain the full amount of Federal financial participation associated with the payment, consistent with the cost identification protocols in the Medicaid State plan and in accordance with § 447.207.

(c) *Other criteria for the use of certified public expenditures.* (1) A State must implement processes by which all claims for medical assistance are processed through Medicaid management information systems in a manner that identifies the specific Medicaid services provided to specific enrollees.

(2) The most recently filed cost reports as specified in paragraph (b)(2) of this section must be used to develop interim payments rates, which may be trended by an applicable health care-related index.

(3) Final settlement must be performed annually by reconciling any interim payments to the finalized cost report for the State plan rate year in which any interim payment rates were made, and final settlement must be made no more than 24 months from the cost report year end, except under circumstances identified in 45 CFR 95.19.

(4) If the final settlement establishes that the provider received an overpayment, the Federal share in recovered overpayment amounts must be credited to the Federal Government, in accordance with part 433, subpart F, of this chapter.

(d) *State plan requirements.* If certified public expenditures are used as a source of non-Federal share under the State plan, the State plan must specify cost protocols in the service payment methodology applicable to the certifying provider that meet all of the following:

(1) Identify allowable cost, using either of the following:

(i) A Medicare cost report, as described in part 413 of this chapter.

(ii) A State-developed Medicaid cost report prepared in accordance with the cost principles in 45 CFR part 75 and 2 CFR part 200.

(2) Define an interim rate methodology for interim payments to providers for services furnished.

(3) Describe an attestation process by which the certifying entity will attest that the costs are accurate and consistent with 45 CFR part 75 and 2 CFR part 200.

(4) Include, as necessary, a list of the covered Medicaid services being furnished by each provider certifying a certified public expenditure.

(5) Define a reconciliation and final settlement process consistent with paragraphs (c)(3) and (4) of this section.

■ 15. Section 447.207 is added to subpart B to read as follows:

§ 447.207 Retention of payments.

(a) *Payments.* Payment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved State plan (or the approved provisions of a waiver or demonstration, if applicable). The Secretary will determine compliance with this paragraph (a) by examining any associated transactions that are related to the provider's total computable Medicaid payment to ensure that the State's claimed expenditure, which serves as the basis for Federal financial participation, is consistent with the State's net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied. Associated transactions may include, but are not necessarily limited to, the payment of an administrative fee to the State for processing provider payments or, in the case of a non-State government provider, for processing intergovernmental transfers. In no event may such administrative fees be calculated based on the amount a provider receives through Medicaid payments or amounts a unit of government contributes through an intergovernmental transfer as funds for the State share of Medicaid service payments.

(b) [Reserved]

■ 16. Section 447.252 is amended by adding paragraphs (d) and (e) to read as follows:

§ 447.252 State plan requirements.

* * * * *

(d) CMS may approve a supplemental payment, as defined in § 447.286, provided for under the State plan or a State plan amendment (SPA) for a period not to exceed 3 years. A State whose supplemental payment approval period has expired or is expiring may request a SPA to renew the supplemental payment for a subsequent period not to exceed 3 years, consistent the requirements of this section. For any State plan or SPA that provides or would provide for a supplemental payment, the plan or plan amendment must specify all of the following:

(1) An explanation of how the State plan or SPA will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including that provision's standards with respect to efficiency, economy, quality of care, and access, along with the stated purpose and intended effects of the supplemental payment, for example, with respect to the Medicaid program, providers, and beneficiaries.

(2) The criteria to determine which providers are eligible to receive the supplemental payment.

(3) A comprehensive description of the methodology used to calculate the

amount of, and distribute, the supplemental payment to each eligible provider, including all of the following:

(i) The amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment.

(ii) If applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed State plan rate year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment.

(iii) The timing of the supplemental payment to each eligible provider.

(iv) An assurance that the total Medicaid payment to an inpatient hospital provider, including the supplemental payment, will not exceed the upper limits specified in § 447.271.

(v) If not already submitted, an upper payment limit demonstration as required by § 447.272 and described in § 447.288.

(4) The duration of the supplemental payment authority (not to exceed 3 years).

(5) A monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries.

(6) For a SPA proposing to renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act.

(e) The authority for State plan provisions that authorize supplemental payments that are approved as of [effective date of the final rule], are limited as follows—

(1) For State plan provisions approved 3 or more years prior to [effective date of the final rule], the State plan authority will expire [*date that is* 2 calendar years following the effective date of the final rule].

(2) For State plan provisions approved less than 3 years prior to [effective date of the final rule], the State plan authority will expire [*date that is* 3 calendar years following the effective date of the final rule].

* * * * *

■ 17. Section 447.272 is amended by revising paragraphs (a)(1) through (3) and (b)(1) to read as follows:

§ 447.272 Inpatient services: Application of upper payment limits.

(a) * * *

(1) State government provider as defined using the criteria set forth in § 447.286.

(2) Non-State government provider as defined using the criteria set forth at § 447.286.

(3) Private provider as defined in § 447.286.

(b) * * *

(1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter, or allowed costs established in accordance with the cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified in part 413 of this chapter. Data elements, methodology parameters, and acceptable upper payment limit demonstration methodologies are specified in § 447.288(b).

* * * * *

■ 18. Subpart D is added to read as follows:

Subpart D—Payments for Services

Sec.

Subpart D—Payments for Services

§ 447.284 Basis and purpose.

(a) This subpart sets forth additional requirements for supplemental payments made under the State plan and implements sections 1902(a)(6) and (a)(30) of the Act.

(b) The reporting requirements in this subpart are applicable to supplemental payments to which an upper payment limit applies under § 447.272 or § 447.321.

§ 447.286 Definitions.

For purposes of this subpart—

Base payment means a payment, other than a supplemental payment, made to a provider in accordance with the payment methodology authorized in the State plan or that is paid to the provider through its participation with a Medicaid managed care organization. Base payments are documented at the beneficiary level in MSIS or T–MSIS and include all payments made to a provider for specific Medicaid services rendered to individual Medicaid beneficiaries, including any payment adjustments, add-ons, or other additional payments received by the provider that can be attributed to a particular service provided to the beneficiary, such as payment adjustments made to account for a higher level of care or complexity of services provided to the beneficiary.

Non-State government provider means a health care provider, as defined in § 433.52 of this chapter, including those defined in § 447.251, that is a unit of local government in a State, including a city, county, special purpose district, or other governmental unit in the State that is not the State, which has access to and exercises administrative control over State funds appropriated to it by the legislature or local tax revenue, including the ability to dispense such funds. In determining whether an entity is a non-State government provider, CMS will consider the totality of the circumstances, including, but not limited to, the following:

(1) The identity and character of any entity or entities other than the provider that share responsibilities of ownership or operation of the provider, and including the nature of any relationship among such entities and the relationship between such entity or entities and the provider. In determining whether an entity shares responsibilities of ownership or operation of the provider, our consideration would include, but would not be limited to, whether the entity:

(i) Has the immediate authority for making decisions regarding the operation of the provider;

(ii) Bears the legal responsibility for risk from losses from operations of the provider;

(iii) Has immediate authority for the disposition of revenue from operations of the provider;

(iv) Has immediate authority with regard to hiring, retention, payment, and dismissal of personnel performing functions related to the operation of the provider;

(v) Bears legal responsibility for payment of taxes on provider revenues and real property, if any are assessed; or

(vi) Bears the responsibility of paying any medical malpractice premiums or other premiums to insure the real property or operations, activities, or assets of the provider.

(2) In determining whether a relevant entity is a unit of a non-State government, we would consider the character of the entity which would include, but would not be limited to, whether the entity:

(i) Is described in its communications to other entities as a unit of non-State government, or otherwise.

(ii) Is characterized as a unit of non-State government by the State solely for the purposes of Medicaid financing and payments, and not for other purposes (for example, taxation).

(iii) Has access to and exercises administrative control over State funds appropriated to it by the legislature and/or local tax revenue, including the ability to expend such appropriated or tax revenue funds, based on its characterization as a governmental entity.

Private provider means a health care provider, as defined in § 433.52 of this chapter, including those defined in § 447.251 of this chapter, that is not a State government provider or a non-State government provider.

State government provider means a health care provider, as defined in § 433.52 of this chapter, including those defined in § 447.251 of this chapter, that is a unit of State government or a State university teaching hospital, which has access to and exercises administrative control over State-appropriated funds from the legislature or State tax revenue, including the ability to dispense such funds. In determining whether a provider is a State government provider, CMS will consider the totality of the circumstances, including, but not limited to, the following:

(1) The identity and character of any entity or entities other than the provider that share responsibilities of ownership or operation of the provider, and including the nature of any relationship among such entities and the relationship between such entity or entities and the provider. In determining whether an entity shares responsibilities of ownership or operation of the provider, our consideration would include, but would not be limited to, whether the entity:

(i) Has the immediate authority for making decisions regarding the operation of the provider;

(ii) Bears the legal responsibility for risk from losses and litigation from operations of the provider;

(iii) Has immediate authority for the disposition of revenue and profit from operations of the provider;

(iv) Has immediate authority with regard to acquisition, retention, payment, and dismissal of personnel performing functions related to the operation of the provider;

(v) Bears legal responsibility for payment of taxes on provider revenues and real property, if any are assessed; or

(vi) Bears the responsibility of paying any medical malpractice premiums or other premiums to insure the real property or operations, activities, or assets of the provider;

(2) In determining whether a relevant entity is a unit of a State government, we would consider the character of the entity which would include, but would not be limited to, whether the entity:

(i) Is described in its communications to other entities as a unit of State government, or otherwise;

(ii) Is characterized as a unit of State government by the State solely for the purposes of Medicaid financing and payments, and not for other purposes (for example, taxation); and

(iii) Has access to and exercises administrative control over State funds appropriated to it by the legislature and/or local tax revenue, including the ability to expend such appropriated or tax revenue funds, based on its characterization as a governmental entity.

Supplemental payment means a Medicaid payment to a provider that is in addition to the base payments to the provider, other than disproportionate share hospital (DSH) payments under subpart E of this part, made under State plan authority or demonstration authority. Supplemental payments cannot be attributed to a particular provider claim for specific services provided to an individual beneficiary and are often made to the provider in a lump sum.

§ 447.288 Reporting requirements for upper payment limit demonstrations and supplemental payments.

(a) *Upper payment limit demonstration reporting requirements.* Beginning October 1, [first year following the year the final rule takes effect] and annually thereafter, by October 1 of each year, in accordance with the requirements of this section and in the manner and format specified by the Secretary, each State must submit a demonstration of compliance with the applicable upper payment limit for each of the following services for which the State makes payment:

(1) Inpatient hospital, as specified in § 447.272.

(2) Outpatient hospital, as specified in § 447.321.

(3) Nursing facility, as specified in § 447.272.

(4) Intermediate care facility for individuals with intellectual disabilities (ICF/IID), as specified in § 447.272.

(5) Institution for mental diseases (IMD), as specified in § 447.272.

(b) *Upper payment limit demonstration standards.* When demonstrating the upper payment limit (UPL), States must use the data sources identified in paragraph (b)(1) of this section, adhere to the data standards specified in paragraph (b)(2) of this section, and use the acceptable methods of demonstrating the UPL specified in paragraph (b)(3) of this section.

(1) *UPL methodology data sources.* The data sources identified in this paragraph (b)(1) are as follows:

(i) Medicare cost demonstrations. Medicare cost demonstrations use cost and charge data for all providers, from either a Medicare cost report or a State-developed cost report which uses either Medicare cost reporting principles specified in part 413 of this chapter or the cost allocation requirements specified in 45 CFR part 75. Cost and charge data must:

(A) Include only data with dates of service that are no more than 2 years prior to the dates of service covered by the upper payment limit demonstration;

(B) Represent costs and charges specifically related to the service subject to the UPL demonstration; and

(C) Include either Medicare costs and Medicare charges, or total provider costs and total provider charges, to develop a cost-to-charge ratio as described in paragraph (b)(3)(i) of this section. The selection must be consistently applied for all providers within the provider category subject to the upper payment limit.

(ii) Medicare payment demonstrations. Medicare payment demonstrations use Medicare payment and charge data for all providers from Medicare cost reports; Medicare payment systems for the specific provider type specified in subchapter B of this chapter, as applicable; or imputed provider payments, specified in paragraph (b)(3)(ii)(C) of this section. When using Medicare payment and charge data, the data must:

(A) Include only data with dates of service that are no more than 2 years prior to the dates of service covered by the upper payment limit demonstration;

(B) Include only Medicare payment and charges, or Medicare payment and Medicare census data, specifically related to the service subject to the UPL demonstration; and

(C) Use either gross Medicare payments and Medicare charges, which includes deductibles and co-insurance in but excludes reimbursable bad debt from the Medicare payment, or net Medicare payments and Medicare charges, which excludes deductibles

and coinsurance from and includes reimbursable bad debt in the Medicare payment, as reported on a Medicare cost report. The selection must be consistently applied for all providers within the provider category subject to the upper payment limit.

(iii) Medicaid charge data and Medicaid census data from a State's Medicaid billing system for services provided during the same dates of service as the Medicare cost or Medicare payment data, as specified in paragraph (b)(1)(i) or (ii) of this section, as applicable.

(iv) Medicaid payment data from a State's Medicaid billing system for services provided during the same dates of service as the Medicare cost or Medicare payment data, as specified in paragraph (b)(1)(i) or (ii) of this section, as applicable, or from the most recent State plan rate year for which a full 12 months of data are available. Such Medicaid payment data must:

(A) Include only data with dates of service that are no more than 2 years prior to the dates of service covered by the upper payment limit demonstration;

(B) Include all actual payments and all projected base and supplemental payments, excluding any payments made for services for which Medicaid is not the primary payer, expected to made during the time period covered by the upper payment limit demonstration to the providers within the provider category, as applicable, during the State plan rate year; and

(C) Only be trended to account for changes in relevant Medicaid State plan payments, except as provided in paragraph (b)(2)(i) of this section.

(2) *UPL methodology data standards.* The data standards specified in this paragraph (b)(2) are as follows:

(i) Projected changes in Medicaid enrollment and utilization must be reflected in the demonstration. At a minimum, the demonstration must be adjusted to account for projected changes in Medicaid enrollment and utilization to reflect programmatic changes, such as reasonable utilization changes due to managed care enrollment projections.

(ii) Medicare cost or payment data may be projected using Medicare trend factors appropriate to the service and demonstration methodology, with such trend factors being uniformly applied to all providers within a provider category.

(iii) When calculating the aggregate upper payment limit using a cost-based demonstration as described in paragraph (b)(3)(i) of this section, the State may include the cost of health care-related taxes paid by each provider in the provider category that is reasonably allocated to Medicaid as an adjustment to the upper payment limit, to the extent that such costs were not already included in the cost-based UPL.

(iv) Medicaid payment data described in paragraph (b)(1)(iv) of this section that is included in the upper payment limit demonstration must only include payments made for the applicable Medicaid services under the specific Medicaid service type at issue in the upper payment limit.

(3) *Acceptable UPL demonstration methods.* The State must demonstration compliance with an applicable UPL using a method described in this paragraph (b)(3).

(i) *Cost-based demonstrations.* Cost-based demonstration data sources are identified in paragraphs (b)(1)(i), (iii), and (iv) of this section and data standards defined in paragraph (b)(2) of this section. To make a cost-based demonstration of compliance with an applicable upper payment limit, Medicaid covered charges are multiplied by a cost-to-charge ratio developed for the period covered by the upper payment limit demonstration. The State may use a ratio of Medicare costs to Medicare charges, or total provider costs to total provider charges in developing the cost-to-charge ratio, but the selection must be applied consistently to each provider within a provider type identified in paragraph (a) of this section. The product of Medicaid covered charges and the cost-to-charge ratio for each provider is summed to determine the aggregate upper payment limit. The demonstration must show that Medicaid payments will not exceed this aggregate upper payment limit for the demonstration period. This methodology may only be used for services where a provider applies uniform charges to all payers. This demonstration may use one of the following demonstration types:

(A) A retrospective demonstration showing that aggregate Medicaid payments paid to the providers within the provider category during the prior State plan rate year did not exceed the costs incurred by the providers furnishing Medicaid services within the prior State plan rate year period.

(B) A prospective demonstration showing that prospective Medicaid payments would not exceed the estimated cost of furnishing the services for the upcoming State plan rate year period.

(ii) *Payment-based demonstrations.* Payment-based demonstration data sources are identified in paragraphs (b)(1)(ii), (iii), and (iv) of this section and data standards defined in paragraph (b)(2) of this section. To make a payment-based demonstration of compliance with an applicable UPL, the State may use one of the following demonstration types:

(A) A retrospective payment-to-charge UPL demonstration where Medicaid covered charges are multiplied by a ratio of Medicare payments to Medicare charges developed for the period covered by the UPL demonstration. The product of Medicaid covered charges and the Medicare payment-to-charge ratio for each provider is summed to determine the aggregate UPL. The demonstration must show that Medicaid payments did not exceed this aggregate UPL;

(B) A prospective payment-to-charge UPL demonstration where Medicaid covered charges are multiplied by a ratio of Medicare payments to Medicare charges developed for the period covered by the UPL demonstration. The product of Medicaid covered charges and the Medicare payment-to-charge ratio for each provider is summed to determine the aggregate UPL. The demonstration must show that proposed Medicaid payments would not exceed this aggregate UPL within the next State plan rate year immediately following the demonstration period; or

(C) A payment-based UPL demonstration using an imputed Medicare per diem payment rate determined by dividing total Medicare prospective payments paid to the provider by the provider's total Medicare patient days, which are derived from the provider's Medicare census data. Each provider's imputed Medicare per diem payment rate is multiplied by the total number of Medicaid patient days for the provider for the period. The products of this operation for each provider are summed to determine the aggregate UPL. The demonstration must show that Medicaid payments are not excess of the aggregate UPL, calculated on either a retrospective or prospective basis, consistent with the methodology described in paragraph (b)(3)(ii)(A) or (B) of this section, as applicable.

(c) *Supplemental payment reporting requirements.* (1) At the time the State submits its quarterly CMS–64 under § 430.30(c) of this chapter, the State must report all of the following information for each supplemental payment included on the CMS–64 on a supplemental report to accompany the CMS–64:

(i) The State plan amendment transaction number or demonstration authority number which authorizes the supplemental payment.

(ii) A listing of each provider that received a supplemental payment under

the SPA or demonstration authority, and for each provider, under each authority listed in paragraph (a) of this section:

(A) The provider's legal name.

(B) The physical address of the location or facility where services are provided, including street address, city, State, and ZIP code.

(C) The National Provider Identifier (NPI).

(D) The Medicaid identification number.

(E) The employer identification number (EIN).

(F) The service type for which the reported payment was made.

(G) The provider specialty type (if applicable, for example, critical access hospital (CAH), pediatric hospital, or teaching hospital).

(H) The provider category (that is, State government provider, Non-state government provider, or Private provider).

(iii) The specific amount of the supplemental payment made to the provider, including:

(A) The total supplemental payment made to the provider authorized under the specified State plan, as applicable.

(B) The total Medicaid supplemental payment made to the provider under the specified demonstration authority, as applicable.

(2) Not later than 60 days after the end of the State fiscal year, each State must annually report aggregate and provider-level information on base and supplemental payments made under State plan and demonstration authority, as applicable, by service type. This reporting must include all of the following:

(i) The SPA transaction number or demonstration authority number which authorizes the supplemental payment, as applicable.

(ii) A listing of each provider that received a supplemental payment under each authority listed in paragraph (a) of this section by:

(A) The provider's legal name.

(B) The physical address of the location or facility where services are provided, including street address, city, State, and ZIP code.

(C) The NPI.

(D) The Medicaid identification number.

(E) The EIN.

(F) The service type for which the reported payment was made.

(G) The provider specialty type (if applicable, for example, CAH, pediatric hospital, or teaching hospital).

(H) The provider category (that is, State government provider, non-State government provider, or Private provider).

(I) The State reporting period (State fiscal year start and end dates).

(iii) The specific amount of Medicaid payments made to each provider, including, as applicable:

(A) The total fee-for-service base payments made to the provider authorized under the State plan.

(B) The total Medicaid payments made to the provider under demonstration authority.

(C) The total amount received from Medicaid beneficiary cost-sharing requirements, donations, and any other funds received from third parties to support the provision of Medicaid services.

(D) The total supplemental payment made to the provider authorized under the specified State plan.

(E) The total Medicaid supplemental payment made to the provider under the specified demonstration authority.

(F) The total Medicaid payments made to the provider as reported under paragraphs (c)(2)(iii)(A) through (E) of this section.

(G) The total disproportionate share hospital (DSH) payments made to the provider.

(H) The Medicaid units of care furnished by the provider, as specified by the Secretary (for example, on a provider-specific basis, total Medicaid discharges, days of care, or any other unit of measurement as specified by the Secretary).

(3) Not later than 60 days after the end of the State fiscal year, each State must annually report aggregate and provider-level information on each provider contributing to the State or any unit of local government any funds that are used as a source of non-Federal share for any Medicaid supplemental payment, by:

(i) The service type for which the reported payment was made.

(ii) The provider specialty type (if applicable, for example, CAH, pediatric hospital, or teaching hospital).

(iii) The provider's legal name.

(iv) The physical address of the location or facility where services are provided, including street address, city, State, and ZIP code.

(v) The NPI.

(vi) The Medicaid identification number.

(vii) The EIN.

(viii) The provider category (that is, State government, non-State government, or private).

(ix) The total fee-for-service base payments made to the provider authorized under the State plan.

(x) The total fee-for-service supplemental payments made to the provider authorized under the State plan.

(xi) The total Medicaid payments made to the provider under demonstration authority.

(xii) The total DSH payments made to the provider.

(xiii) The total of each health care-related tax collected from the provider by any State authority or unit of local government.

(xiv) The total of any costs certified as a certified public expenditures (CPE) by the provider.

(xv) The total amount contributed by the provider to the State or a unit of local government in the form of an intergovernmental transfers (IGT).

(xvi) The total of provider-related donations made by the provider or by entities related to a health care provider, including in-cash and in-kind donations, to the State or a unit of local government, including State university teaching hospitals.

(xvii) The total funds contributed by the provider reported in paragraphs (c)(3)(xiii) through (xvi) of this section.

§ 447.290 Failure to report required information.

(a) The State must maintain the underlying information supporting base and supplemental payments, including the information required to be reported under § 447.288, consistent with the requirements of § 433.32 of this chapter, and must provide such information for Federal review upon request to facilitate program reviews or Department of Health and Human Services' Office of Inspector General (OIG) audits conducted under §§ 430.32 and 430.33 of this chapter.

(b) If a State fails to timely, completely and accurately report information required under § 447.288, CMS may reduce future grant awards through deferral in accordance with § 430.40 of this chapter, by the amount of Federal financial participation (FFP) CMS estimates is attributable to payments made to the provider or providers as to which the State has not reported properly, until such time as the State complies with the reporting requirements. CMS may defer FFP if a State submits the required report but the report fails to comply with applicable requirements. Otherwise allowable FFP for expenditures deferred in accordance with this section will be released when CMS determines that the State has complied with all reporting requirements under § 447.288.

§ 447.297 [Amended]

■ 19. Section 447.297 is amended—

■ a. In paragraph (b) by removing the phrase ''published by April 1 of each Federal fiscal year,'' and adding in its

place the phrase ''posted as soon as practicable''

■ b. In paragraph (c) by removing the phrase ''publish in the **Federal Register**'' and adding in its place the phrase ''post in the Medicaid Budget and Expenditure System and at *Medicaid.gov* (or similar successor system or website)'' and by removing the phrase ''publish final State DSH allotments by April 1 of each Federal fiscal year,'' and adding in its place the phrase ''post final State DSH allotments as soon as practicable in each Federal fiscal year,''

■ c. In paragraph (d)(1) by removing the phrase ''by April 1 of each Federal fiscal year'' and adding in its place the phrase ''as soon as practicable for each Federal fiscal year'' and by removing the phrase ''prior to the April 1 publication date'' and adding in its place the phrase ''prior to the posting date''

■ 20. Section 447.299 is amended by—

■ a. Redesignating paragraph (c)(21) as paragraph (c)(22)

■ b. Adding new paragraph (c)(21) and paragraphs (f) and (g).

The additions read as follows:

§ 447.299 Reporting requirements.

* * * * *

(c) * * *

(21) *Financial impact of audit findings.* The total annual amount associated with each audit finding. If it is not practicable to determine the actual financial impact amount, state the estimated financial impact for each audit finding identified in the independent certified audit that is not reflected in data elements described in paragraphs (c)(6) through (15) of this section. For purposes of this paragraph (c)(21), audit finding means an issue identified in the independent certified audit required under § 455.304 of this chapter concerning the methodology for computing the hospital specific DSH limit and/or the DSH payments made to the hospital, including, but not limited to, compliance with the hospital-specific DSH limit as defined in paragraph (c)(16) of this section. Audit findings may be related to missing or improper data, lack of documentation, non-compliance with Federal statutes and/or regulations, or other deficiencies identified in the independent certified audit. Actual financial impact means the total amount associated with audit findings calculated using the documentation sources identified in § 455.304(c) of this chapter. Estimated financial impact means the total amount associated with audit findings calculated on the basis of the most reliable available information to quantify the amount of an audit finding in circumstances where complete and accurate information necessary to determine the actual financial impact is not available from the documentation sources identified in § 455.304(c) of this chapter.

* * * * *

(f) DSH payments found in the independent certified audit process under part 455, subpart D, of this chapter to exceed hospital-specific cost limits are provider overpayments which must be returned to the Federal Government in accordance with the requirements in part 433, subpart F, of this chapter or redistributed by the State to other qualifying hospitals, if redistribution is provided for under the approved State plan. Overpayment amounts returned to the Federal Government must be separately reported on the Form CMS–64 as a decreasing adjustment which corresponds to the fiscal year DSH allotment and Medicaid State plan rate year of the original DSH expenditure claimed by the State.

(g) As applicable, States must report any overpayment redistribution amounts on the Form CMS–64 within 2 years from the date of discovery that a hospital-specific limit has been exceeded, as determined under § 433.316(f) of this chapter in accordance with a redistribution methodology in the approved Medicaid State plan. The State must report redistribution of DSH overpayments on the Form CMS–64 as separately identifiable decreasing adjustments reflecting the return of the overpayment as specified in paragraph (f) of this section and increasing adjustments representing the redistribution by the State. Both adjustments should correspond to the fiscal year DSH allotment and Medicaid State plan rate year of the related original DSH expenditure claimed by the State.

■ 21. Section 447.302 is revised to read as follows:

§ 447.302 State plan requirements.

(a) The plan must provide that the requirements of this subpart are met.

(b) The plan must specify comprehensively the methods and standards used by the agency to set payment rates.

(c) CMS may approve a supplemental payment, as defined in § 447.286, provided for under the State plan or a State plan amendment for a period not to exceed 3 years. A State whose supplemental payment approval period has expired or is expiring may request a State plan amendment to renew the supplemental payment for a subsequent period not to exceed 3 years, consistent the requirements of this section. For any State plan or State plan amendment that provides or would provide for a supplemental payment, the plan or plan amendment must specify all of the following:

(1) An explanation of how the State plan or State plan amendment will result in payments that are consistent with section 1902(a)(30)(A) of the Act, including that provision's standards with respect to efficiency, economy, quality of care, and access along with the stated purpose and intended effects of the supplemental payment, for example, with respect to the Medicaid program, providers and beneficiaries.

(2) The criteria to determine which providers are eligible to receive the supplemental payment.

(3) A comprehensive description of the methodology used to calculate the amount of, and distribute, the supplemental payment to each eligible provider, including all of the following:

(i) The amount of the supplemental payment made to each eligible provider, if known, or, if the total amount is distributed using a formula based on data from one or more fiscal years, the total amount of the supplemental payments for the fiscal year or years available to all providers eligible to receive a supplemental payment.

(ii) If applicable, the specific criteria with respect to Medicaid service, utilization, or cost data from the proposed State plan payment year to be used as the basis for calculations regarding the amount and/or distribution of the supplemental payment.

(iii) The timing of the supplemental payment to each eligible provider.

(iv) An assurance that the total Medicaid payment to other inpatient and outpatient facilities, including the supplemental payment, will not exceed the upper limits specified in § 447.325.

(v) If not already submitted, an upper payment limit demonstration as required by § 447.321 and described in § 447.288.

(4) The duration of the supplemental payment authority (not to exceed 3 years).

(5) A monitoring plan to ensure that the supplemental payment remains consistent with the requirements of section 1902(a)(30)(A) of the Act and to enable evaluation of the effects of the supplemental payment on the Medicaid program, for example, with respect to providers and beneficiaries.

(6) For a SPA proposing to amend or renew a supplemental payment for a subsequent approval period, an evaluation of the impacts on the Medicaid program during the current or most recent prior approval period, for

example, with respect to providers and beneficiaries, and including an analysis of the impact of the supplemental payment on compliance with section 1902(a)(30)(A) of the Act.

(d) The authority for State plan provisions that authorize supplemental payments that are approved as of [effective date of the final rule], is limited as follows—

(1) For State plan provisions approved 3 or more years prior to [effective date of the final rule], the State plan authority will expire [date that is 2 calendar years following the effective date of the final rule].

(2) For State plan provisions approved less than 3 years prior to [effective date of the final rule], the State plan authority will expire [date that is 3 calendar years following the effective date of the final rule].

■ 22. Section 447.321 is amended by revising the section heading and paragraphs (a) and (b)(1) to read as follows:

§ 447.321 Outpatient hospital services: Application of upper payment limits.

(a) *Scope.* This section applies to rates set by the agency to pay for outpatient services furnished by hospitals within one of the following categories:

(1) State government provider, as defined using the criteria set forth at § 447.286.

(2) Non-State government provider, as defined using the criteria set forth at § 447.286.

(3) Private provider, as defined using the criteria set forth at § 447.286.

(b) * * *

(1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter, or allowed costs established in accordance with the cost principles as specified in 45 CFR part 75 and 2 CFR part 200, or, as applicable, Medicare cost principles specified at 42 CFR part 413. Data elements, methodology parameters, and acceptable upper payment limit demonstration methodologies are defined in § 447.288(b).

* * * * *

■ 23. Section 447.406 is added to read as follows:

§ 447.406 Medicaid practitioner supplemental payment.

(a) *General.* This section applies to Medicaid practitioner supplemental payments, which, for purposes of this section, are supplemental payments as defined in § 447.286 that are authorized under the State plan for practitioner services and targeted to specific practitioners under a methodology specified in the State plan. This section does not apply to value-based payment methodologies that are part of a State's delivery system reform initiative, are attributed to a particular service provided to a Medicaid beneficiary, and that are available to all providers, including as an alternative to fee-for-service payment rates.

(b) *Medicaid practitioner supplemental payment standards.* A Medicaid practitioner supplemental payment must meet the requirements specified in § 447.302, including the transition period requirements in paragraph (d) of that section, as well as the requirements specified in this section.

(c) *Medicaid practitioner supplemental payment limit.* Medicaid practitioner supplemental payments may not exceed—

(1) 50 percent of the total fee-for-service base payments authorized under the State plan paid to an eligible provider for the practitioner services during the relevant period; or

(2) For services provided within HRSA-designated geographic health professional shortage areas (HPSA) or Medicare-defined rural areas as specified in 42 CFR 412.64(b), 75 percent of the total fee-for-service base payments authorized under the State plan paid to the eligible provider for the practitioner services during the relevant period.

PART 455—PROGRAM INTEGRITY: MEDICAID

■ 24. The authority citation for part 455 continues to read as follows:

Authority: 42 U.S.C 1302.

■ 25. Section 455.301 is amended by revising the definition of ''Independent certified audit'' to read as follows:

§ 455.301 Definitions.

* * * * *

Independent certified audit means an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospitals and is eligible to perform the disproportionate share hospital (DSH) audit. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification includes a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, a determination of whether or not the State made DSH payments that exceeded any hospital's hospital-specific DSH limit in the Medicaid State plan rate year under audit, and the financial impact of each audit finding on a hospital-specific basis. The certification also identifies any data issues or other caveats or deficiencies that the auditor identified as impacting the results of the audit.

* * * * *

PART 457—ALLOTMENTS AND GRANTS TO STATES

■ 26. The authority for part 457 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 27. Section 457.609 is amended by revising paragraph (h) to read as follows:

§ 457.609 Process and calculation of State allotments for a fiscal year after FY 2008.

* * * * *

(h) *CHIP fiscal year allotment process.* The national CHIP allotment and State CHIP allotments will be posted in the Medicaid Budget and Expenditure System and at *Medicaid.gov* (or similar successor system or website) as soon as practicable after the allotments have been determined for each Federal fiscal year.

Dated: September 12, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 7, 2019.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2019–24763 Filed 11–12–19; 4:15 pm]

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December 11, 2019

Mr. Govind Nadkarni
8105 Valdemorillo
Corpus Christi, TX 78414

Dear Mr. Nadkarni;

This letter is to clarify that on Wednesday, November 20, 2019, the Nueces County Commissioners Court nominated (not appointed) you to the Nueces County Hospital District's Board of Managers for consideration of an appointment by them to the CHRISTUS Spohn Health System Corporation Board of Trustees for a 3-year term expiring December, 2022.

Your nomination above has been forwarded to the Board of Managers for consideration and action at their next regular meeting; you will notified directly by the District's Administrator of the Board of Managers action.

If there are changes in your contact information, please call 361-888-0878 or if you have any other questions.

Best wishes,

Barbara Canales
Nueces County Judge

BC.mlm

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NUECES COUNTY HOSPITAL DISTRICT
POLICY AND PROCEDURE

Date of Origin: June 1, 1998 Date of Revision: November 1, 2009 Date of Review:	Authorized By: Administrator:	Approved By:

Title: HOLIDAYS **Policy: 302.2**

I. POLICY

Full time employees are authorized days away from work for the holidays recognized by the Nueces County Hospital District. The holiday year extends from January 1 through December 31. The holidays recognized are New Year's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day and day after Thanksgiving and two (2) days during the Christmas Holiday at which will be determined due to yearly date changes. Nueces County Hospital District offices will be closed for these ten major holidays. If a recognized holiday falls on a non-workday, NCHD will notify employees of the alternative date for the holiday.

Pay for a holiday is included in Paid Time Off benefits and time away from work for holidays and will be deducted from employees' accrued Paid Time Off balance.

II. PURPOSE

The purpose of this policy is to define the recognized holidays and establish guidelines for time off during holidays.

III. RESPONSIBILITY

Supervisors are responsible for scheduling time off for holidays and for scheduling any additional days off during holidays.

IV. GUIDELINES

A. As with all time away from work, employees must have time away from work during the holidays approved by their supervisors.

B. Employees with adequate accrued PTO benefits will record the holiday as 8 hours of PTO time on the NCHD pay sheet.

C. Employees without adequate accrued PTO hours will take the holiday off with pay for any accrued PTO hours and without pay for the rest of the 8 hours. Employees will write the PTO hours and the hours "without pay" on the NCHD pay sheet next to the holiday.

NUECES COUNTY HOSPITAL DISTRICT
POLICY AND PROCEDURE

Date of Origin: June 1, 1998 Date of Revision: November 1, 2009 Date of Review:	Authorized By: Administrator:	Approved By:

Title: PAID TIME OFF (PTO) **Policy: 302.4**

I. POLICY

The Nueces County Hospital District considers paid time away from work essential to maintaining the morale and productivity of its employees. Such time is an opportunity to become refreshed mentally and physically and thus be better prepared for carrying out job responsibilities.

The Nueces County Hospital District has established a Paid Time Off (PTO) program to provide a positive and equitable plan that permits the employee to be paid for absences from work for personal reasons as delineated in Paragraph IV (B). It combines into one plan benefits associated with holidays and vacation. The amount of PTO time accrued by an employee is determined by the employee's status of employment and length of service as set out below.

The PTO program was developed to provide greater flexibility for employees in the use of earned time off benefits and to encourage employees to plan and schedule time off thus decreasing unscheduled absences from work.

Not withstanding the above, and in consideration of the ongoing business needs of the Hospital District, eligible employees may exchange certain limited accrued PTO hours for discounted compensation in accordance with this policy.

II. PURPOSE

The purpose of this policy is to define benefits and establish guidelines governing the use of Paid Time Off.

III. RESPONSIBILITY

Employees are responsible for scheduling time away from work with their supervisors.
Supervisors are responsible for reviewing the requests by employees for days away from work and either approving or disapproving the requests based on the requirements of the work place.

IV. PTO BENEFITS

A. Employees will accrue Paid Time Off (PTO) benefits each pay period based on full time employment status and length of service.

40 Hours Per Week Accrual Schedule

Years of Service	Accrual	Days
0 - 60 months (1st - 5th year)	26 pay periods x 7.385 = 192 hrs	24
61 - 72 months (6th year)	26 pay periods x 7.693 = 200 hrs	25
73 - 84 months (7th year)	26 pay periods x 8.000 = 208 hrs	26
85 - 96 months (8th year)	26 pay periods x 8.308 = 216 hrs	27
97 - 108 months (9th year)	26 pay periods x 8.616 = 224 hrs	28
109 - 168 months (10th - 14th year)	26 pay periods x 8.924 = 232 hrs	29
>169 months (15th year & over)	26 pay periods x 10.462 = 272 hrs	34

32-39 Hours Per Week Accrual Schedule

Years of Service	Accrual	Days
0 - 60 months (1st - 5th year)	26 pay periods x 6.154 = 160 hrs	20
61 - 72 months (6th year)	26 pay periods x 6.462 = 168 hrs	21
73 - 84 months (7th year)	26 pay periods x 6.770 = 176 hrs	22
85 - 96 months (8th year)	26 pay periods x 7.077 = 184 hrs	23
97 - 108 months (9th year)	26 pay periods x 7.385 = 192 hrs	24
109 - 168 months (10th - 14th year)	26 pay periods x 7.693 = 200 hrs	25
>169 months (15th year & over)	26 pay periods x 9.231 = 240 hrs	30

B. Accrued PTO will be used to compensate employees at their base hourly rate of pay when they are away from work for short-term excused absences including:

1. Vacations
2. Holidays
3. Family emergencies and illnesses
4. Religious observances
5. Preventative health and dental care
6. Personal business
7. Other as approved by the employees supervisor

C. The hours of PTO an employee accrues in each pay period will be based on the eligible work hours and the eligible benefit hours paid to the employee during the pay period. Regular hours, PTO hours, Civil Leave hours and Bereavement Leave hours are considered eligible hours and will accrue PTO benefits. Leave of Absence or other unpaid time away from work and overtime hours are not eligible hours for accrual of PTO.

D. The maximum number of hours eligible for PTO payment during any pay period will not exceed eighty (80) hours.

V. ELIGIBILITY

A. Full-time employees scheduled to work at least thirty-two (32) hours per week will earn PTO in accordance with the earning schedule listed under Paragraph IV (A) PTO Benefits.

B. All full-time employees will begin accruing PTO on their first day of employment. However, the PTO time is not considered vested until the employee completes six (6) months of employment.

VI. USE OF PTO

A. Employees may not schedule and use PTO time until after the completion of the first six (6) months of employment, except for holidays that fall within the pay period. If a recognized holiday falls during the six (6) month period, the employee may use PTO time to cover the holiday if the PTO time has already been accrued. After completion of the first six months of employment, PTO may be used as earned, with the approval of the employee's supervisor. PTO benefits will not be paid prior to accrual.

B. At the supervisors discretion employees' are to use the "Request for Time Away from Work" form to request PTO time away from work or an email request may be sent to the supervisor. The employees' supervisor will document approval or disapproval of the employees request to schedule PTO time on the "Request for Time Away from Work" form and send a copy of the form to the employee or by email response. The original form will be filed in the employees file. (Attachment 1, Request for Time Away from Work)

C. Employees should submit requests for time off to their supervisor as far in advance as possible. When unanticipated absences are necessary for illnesses or emergencies, the employee will notify their supervisor as soon as possible. The employee should complete the "Request for Time Away from Work" form or send an email the next scheduled working day, but no later than the end of the pay period in which the absence occurred.

D. Employees who fail to notify their supervisors in advance to allow for staffing adjustments may not receive approval for PTO pay for unscheduled absences. Repeated failure to provide advance notice or excessive use of unscheduled PTO time may result in disciplinary action up to and including termination.

E. An employee's supervisor reserves the right to approve or disapprove all requests for time away from work based on the needs of NCHD. Whenever possible, PTO will be scheduled in conjunction with the desires of the employee.

F. PTO hours will not be used to compensate employees for tardiness.

G. Employees who are on disciplinary or investigatory suspension without pay may not use PTO time during the suspension.

H. Employees may not use PTO time during a Leave of Absence. An employee will not accrue PTO during a Leave of Absence.

I. Sick Leave time, Bereavement Leave time and Civil Leave time are benefits provided separately from PTO benefits and employees are not required to use PTO hours when away from work for one of these reasons.

VII. PAYMENT OF PTO

A. PTO will be paid at the employee's current base hourly rate when approved by the employee's supervisor.

B. PTO will be paid in units of no less than one (1) hour.

C. An employee may receive no more than the equivalent of his/her regularly scheduled bi-weekly time in PTO per pay period.

VIII. MAXIMUM ACCRUAL OF PTO BENEFITS

A. Employees are encouraged to use all of their accrued PTO during their service year. It is the employee's responsibility to request time off and to work out an acceptable schedule with his/her supervisor.

B. When the volume of work is such that employees are unable to use all accrued time within the service year, they may carry forward their accrued PTO balance to the next year. An employee's maximum accrual balance may not exceed a total of two (2) years PTO accrual. An employee who has reached the maximum PTO accrual will not accrue additional PTO until the balance falls below two (2) years maximum accrual.

IX. EXCHANGE OF ACCRUED PTO HOURS FOR DISCOUNTED COMPENSATION

A. In consideration of the ongoing business needs of the Hospital District, eligible employees may exchange certain limited accrued PTO hours for discounted compensation as set forth below.

B. An employee is eligible to participate in the exchange of certain limited accrued PTO hours for discounted compensation when the following conditions are met:

1. The employee has satisfactorily completed his/her initial introductory period of employment with NCHD; and

2. The employee's current performance is satisfactory and the employee is not undergoing disciplinary action; and

3. The employee has accrued PTO sufficient to allow the exchange of at least sixteen (16) hours of PTO and retain a minimum of eighty (80) hours of PTO **after** exercising the exchange.

C. Eligible employees may exchange only those PTO hours for that accrue during and after the Hospital District pay period beginning March 30, 2002.

D. Eligible employees may request an exchange of accrued PTO hours discounted compensation during the second pay periods of May and November. An employee may not request and exchange of accrued PTO at any other time.

E. The amount of accrued PTO hours eligible for exchange is based on the number of total PTO hours accrued as of the end of the pay period immediately preceding the pay period in which the request for exchange occurs.

F. An eligible employee wishing to exercise the exchange must complete the "Employee PTO Exchange Form" and have the request approved by his/her immediate supervisor. The employee's supervisor will forward the form to the HR Department for processing. (Attachment 2, Employee PTO Exchange Form).

G. Eligible employees will be compensated for exchanged PTO hours at eighty percent (80%) of their current hourly rate.

H. Exchanged PTO hours will be compensated in the pay period immediately following the approved request for exchange.

X. TERMINATION OF EMPLOYMENT

A. Employees who terminate employment after six (6) months of service and leave in good standing will be paid all accrued unused PTO hours.

B. Employees who resign with less than six months of service or employees discharged for cause (misconduct) will not be paid accrued PTO benefits.

NUECES COUNTY HOSPITAL DISTRICT
Administrative Offices

555 N. Carancahua Street, Suite 950
Corpus Christi, Texas 78401-0835

Phone: (361) 808-3300
Fax: (361) 808-3274

BOARD OF MANAGERS ORDER
DECEMBER 17, 2019

AUTHORIZING LITIGATION AND SPECIAL COUNSEL AGREEMENT WITH PHIPPS DEACON PURNELL PLLC. (COUNSEL FOR NUECES COUNTY HOSPITAL DISTRICT PROPERTY TAX LITIGATION)

WHEREAS, the Nueces County Hospital District ("Hospital District" or "District") is a body politic and corporate and a political subdivision of the State of Texas, established and created pursuant to the Texas Constitution, Article IX, Section 4 and the Texas Health and Safety Code (the "Health Code"), Chapter 281, and operated in accordance with the Health Code and other applicable laws of the State of Texas, including the Texas Local Government Code (the "Local Government Code"), Chapter 116;

WHEREAS, the Hospital District's Board of Managers ("Board") have been duly appointed pursuant to Health Code, § 281.021(a); and pursuant to the collective authorities of Health Code, § 281.047 and § 281.048, the Board is the District's governing body and the Board has, and at the time of adoption of this Order had, full power and authority to manage, control, administer, and to adopt rules governing operation of the District;

WHEREAS, there is a substantial need for the legal services;

WHEREAS, the legal services cannot be adequately performed by the attorneys and supporting personnel of Nueces County Hospital District or by the attorneys and supporting personnel of another public agency; and

WHEREAS, the legal services cannot reasonably be obtained by attorneys in private practice under a contract providing only for the payment of hourly fees, without regard to the outcome of the matter, because of the nature of the matter for which the services will be obtained and because Nueces County Hospital District does not have appropriated funds available to pay the estimated amounts required under a contract providing only for the payment of hourly fees.

NOW, THEREFORE, BE IT ORDERED BY THE BOARD OF MANAGERS:

1. An exemption from competitive bidding and proposal procedures in accordance with Texas Local Government Code Section 272.024(a)(4).

2. The selection of Special Counsel and the terms and conditions of the employment of such counsel.

3. Authorizing the County Attorney and Special Counsel to file such claims and litigation as the County Attorney deems necessary against Valero for pending and subsequent property tax litigation related to tax years 2018, 2019, and 2020.

4. The Hospital District's Administrator designee is authorized to execute on behalf of Nueces County Hospital District an agreement with Special Counsel containing terms and provisions substantially similar to those contained in the attached agreement.

5. All fees to be paid to Special Counsel are contingent upon the recovery of attorney's fees and damages as provided for in the Agreement and no money shall be due or paid from the General Fund or any special fund under this Agreement.

6. All Nueces County Hospital District officials and employees are authorized to do any and all things necessary or convenient to accomplish the purposes of this order.

# # #

DULY ADOPTED BY VOTE OF THE BOARD OF MANGERS OF NUECES COUNTY HOSPITAL DISTRICT ON THE 17th DAY OF DECEMBER, 2019.

_____

John B. Martinez
Chairman

_____

Sylvia Tryon Oliver
Vice Chairman

_____

Belinda Flores
Member

_____

Vishnu V. Reddy, M.D.
Member

_____

Pamela L. Brower
Member

_____

Daniel W. Dain
Member

_____

John E. Valls
Member

CERTIFICATE OF SECRETARY

THE STATE OF TEXAS §
§
COUNTY OF NUECES §
§
NUECES COUNTY HOSPITAL DISTRICT §

THE UNDERSIGNED HEREBY CERTIFIES that:

1. The members of the Board of Managers (the "Board") of the Nueces County Hospital District (the "Hospital District") have been duly appointed pursuant to Texas Health and Safety Code (the "Health Code"), §281.021.

2. Pursuant to Health Code, §281.021(a), the Hospital District's Board of Managers (the "Board") have been duly appointed; pursuant to Health Code, §281.048, the Board is the governing body of the Hospital District; and pursuant to the collective authorities of Health Code, §281.047 and §281.048, the Board has, and the time of adoption of this Order had, full power and authority to manage, control, administer, and to adopt rules governing operation of the Hospital District.

3. On the **17th day of December, 2019** the Board convened in a regular meeting at the Hospital District's regular meeting place (the "Meeting"), the duly constituted members and officers of the Board being as follows:

John B. Martinez, Chairman
Sylvia Tryon Oliver, Vice Chairman
Belinda Flores
Vishnu V. Reddy, M.D.
Pamela L. Brower
Daniel W. Dain
John E. Valls

and all of said persons were present, except the following absentees:

_____, _____,
and _____, thus constituting a quorum.

4. Among other business considered at the Meeting, the attached order entitled:

AUTHORIZING LITIGATION AND SPECIAL COUNSEL AGREEMENT WITH PHIPPS DEACON PURNELL PLLC. (COUNSEL FOR NUECES COUNTY HOSPITAL DISTRICT PROPERTY TAX LITIGATION)

is a true copy of an order introduced and submitted to the Board for consideration toward passage and adoption (the "Order"). After presentation and discussion, it was then duly moved and seconded that the Order be passed and adopted. The motion to pass and adopt the Order prevailed and carried by the following viva voce vote:

YEAS: ____
NAYS: ____
PRESENT NOT VOTING: ____
ABSENT: ____

all as shown in the official Minutes of the Board for the Meeting.

5. The attached Order is a true and correct copy of the original on file in the official records of the Hospital District; the duly qualified and acting members of the Board on the date of the Meeting are those persons shown above, and, according to the records of my office, each member of the Board was given actual notice of the time, place, and purpose of the Meeting and had actual notice that the Order would be considered; and the Meeting and deliberation of the aforesaid public business, was open to the public and written notice of said meeting, including the subject of the Order, was posted and given in advance thereof in compliance with the provisions of Chapter 551, Texas Government Code, as amended.

6. I am the Secretary of the Board having been duly appointed pursuant to Health Code, §281.023(b).

7. The foregoing Order is in full force and effect; that the same has not been rescinded, nor has it been amended or modified in any way.

IN WITNESS WHEREOF, I have hereunto signed my name officially and affixed the seal of the Hospital District on this the **17th day of December, 2019**.

_____

Jonny F. Hipp
Secretary, Board of Managers
Nueces County Hospital District

{HOSPITAL DISTRICT SEAL}

PHIPPS DEACON PURNELL PLLC

October 17, 2019

Ronnie Canales
Chief Appraiser
Nueces County Appraisal District
201 North Chaparral Street
Corpus Christi, Texas 78401

Dear Ronnie:

We are looking forward to working with you and your team to ensure fairness in the property valuation system in Nueces County. We are breaking new ground, and excited to get to work.

Please find enclosed a signed legal services agreement. It will require approval by the Nueces Appraisal District Board of Directors, Nueces County Commissioners Court, Corpus Christi City Council, Del Mar College Board of Regents, and Corpus Christi Independent School District Board of Trustees, and the Texas Attorney General. This is the beginning of a long journey against formidable opposition. It is not a challenge we take lightly.

Our firm motto is that "artists lead and hacks ask for a show of hands." We have represented thousands of clients in 36 states and two foreign countries in complex economic damages cases. But every case comes down to three values: character, integrity, and honesty. Together we will do the right thing for Nueces County property taxpayers.

Sincerely,

Martin J. Phipps
Managing Partner

CC: Tom C. Wheat, General Counsel

PROFESSIONAL SERVICES AGREEMENT
(Contingent Fee Counsel for Nueces County Property Tax Litigation)

The Parties to this Agreement ("Agreement") are Nueces County Appraisal District, Corpus Christi ISD, City of Corpus Christi, County of Nueces, Del Mar College, and Nueces County Hospital District ("CLIENTS") and PHIPPS DEACON PURNELL pllc ("COUNSEL").

In consideration of the following mutual promises, the Parties agree as follows:

A. Purpose of Representation

1.01 CLIENTS, individually and collectively, have found a substantial need to employ COUNSEL to assist CLIENTS in the prosecution of property tax litigation against Valero Refining – Texas, L.P. and any and all other similar situated commercial property located within the County, including all their corporate affiliates, parents, and subsidiaries (referred to as "Valero") related to tax years 2018, 2019, and 2020 (referred as "Representation"). This Agreement expressly encompasses the prosecution of all pending and subsequent property tax litigation between CLIENTS and Valero related to tax years 2018, 2019, and 2020 including, without limitation, all claims of CLIENTS related to the value or appraised value of Valero property in Nueces County, all claims of CLIENTS related to the property tax liability of Valero in regards to Valero property situated in Nueces County, and all other property tax claims of CLIENTS against Valero.

1.02 CLIENTS retain and employ COUNSEL. CLIENTS, individually and collectively, find that there is a substantial need for the legal services which are the subject of this Agreement, that the legal services cannot be adequately performed by the attorneys and supporting personnel of CLIENTS, and that the legal services cannot reasonably be obtained from attorneys in private practice under a contract providing only for payment of hourly fees, without regard to the outcome of the matter, because of the nature of the matter for which the services will be obtained or because CLIENTS, individually and collectively, do not have funds to pay the estimated amounts required under a contract providing only for the payment of hourly fees. The estimated amount at issue in the litigation exceeds $100,000.00.

1.03 CLIENTS hereby authorize and direct COUNSEL, to handle the Representation and to take all actions necessary to prosecute and assist in the prosecution of the ongoing case or any new or additional case(s) on behalf of CLIENTS against Valero. In the Representation, COUNSEL may seek necessary and appropriate injunctive relief, damages, civil penalties, costs and attorney's fees, and such other pecuniary recovery as may be provided for by the laws of the State of Texas and/or any relevant local, state and/or federal statutory and/or common law. COUNSEL shall furnish the services for the Representation. COUNSEL agrees to perform necessary legal work with reference to the Representation.

1.04 Each CLIENT named in this Agreement represents that it is authorized to enter into this Agreement in accordance with applicable law, including that it has satisfied all requirements of Tex. Govt. Code §§ 2254.1032 and 2254.1036 prior to executing this Agreement.

1.05 CLIENTS, individually and collectively, have determined that this Agreement is for *professional services*, requiring work that is predominantly mental or intellectual, rather than physical or manual, requiring special knowledge or attainment and a high order of learning, skill, and academic intelligence and the services of COUNSEL are being retained pursuant to all applicable law.

1.06 COUNSEL represents CLIENTS and COUNSEL's attorney-client relationship does not include any other persons or entities. If any potential conflict arises with respect to the Representation, COUNSEL will make full disclosure of the possible effects of such Representation on the professional judgment of each individual associated with COUNSEL working on the Representation. Such disclosure shall be made to each CLIENT by giving written notice sent in accordance with Section 5.05 of this Agreement.

1.07 It is understood and agreed that COUNSEL's engagement is limited to the Representation. COUNSEL's acceptance of this Agreement does not imply any undertaking to provide legal services other than those set forth in this Agreement.

1.08 It is expressly understood that COUNSEL has no authority to settle or otherwise compromise the position of CLIENTS or any of CLIENTS' officers. CLIENTs retain all authority to settle any case or cases which are the subject of the Representation.

1.09 Any expressions on COUNSEL's part concerning the outcome of the Representation, or any other legal matters, are based on COUNSEL's professional judgment and are not guarantees. Such expressions, even when described as opinions, are necessarily limited by COUNSEL's knowledge of the facts and are based on COUNSEL's views of the state of the law at the time they are expressed. COUNSEL has made no promises or guarantees to CLIENTS about the outcome of the Representation, and nothing in these terms of engagement shall be construed as such a promise or guarantee.

B. Compensation and Other Matters

2.01 For and in consideration of the services performed under this Agreement, CLIENTS agree to pay COUNSEL a contingent fee in the amount set forth herein.

2.02 The amount of the contingent fee will not exceed the lesser of the stated percentage of the amount recovered (as set forth in Section 2.03) or the amount computed under Tex. Govt. Code. 2254.106(a), (b), and (c) (as set forth in Section 2.04). The contingent fee shall be computed in accordance with Tex. Govt. Code 2254.106(g) for each individual recovery that exceeds $100,000.

2.03 **The Method by Which the Contingent Fee is Computed as a Percentage of the Amount Recovered.** The amount of the contingent fee shall be an amount equal to thirty-five percent (35%) of the gross amount recovered above the 2017 values for the properties in question, whether by judgment, settlement, or otherwise. Any contingency fee due hereunder is to be computed by multiplying CLIENTS' gross recovery by thirty-five (35%). This is the method by which the contingent fee is computed as a percentage of the amount recovered.

2.04 **The Method by Which the Contingent Fee is Computed Under Tex. Govt. Code 2254.106 (a), (b) and (c).** A "Base Fee" shall be calculated as follows: For each attorney, law clerk, or paralegal who is a contracting attorney or a partner, shareholder, or employee of a contracting attorney or law firm, multiply the number of hours the attorney, law clerk, or paralegal works in providing legal or support services under the contract times the reasonable hourly rate for the work performed by that attorney, law clerk, or paralegal. Add the resulting amounts to obtain the Base Fee. The computation of the Base Fee may not include hours or costs attributable to work performed by a person who is not a contracting attorney or a partner, shareholder, or employee of a contracting attorney or law firm.

The reasonable hourly rate for work performed by an attorney, law clerk, or paralegal who will perform legal or support services under this Agreement based on the reasonable and customary rate in the relevant locality for the type of work performed and on the relevant experience, demonstrated ability, and standard hourly billing rate, if any, of the person performing the work shall be:

a. MARTIN J. PHIPPS, BARRY DEAON, SIMON PURNELL, T.J. MAYES, JASON MILNE	$1,000
b. MEAGAN TALAFUSE, VANESSA CANTU, GABE ORTIZ, CHASE HARDY	$750
c. Other attorneys employed by COUNSEL:	
(1) Attorneys with 15+ years of litigation experience	$900
(2) Attorneys with 10 to 15 years of litigation experience	$600
(3) Attorneys with 5 to 10 years of litigation experience	$450
(4) Attorneys with 1 to 5 years of litigation experience	$350
d. Law clerks employed by COUNSEL	$150
e. Paralegals employed by COUNSEL	$200

The contingent fee is then computed by multiplying the "Base Fee" by a multiplier. Based on the expected difficulties in performing the contract, the amount of expenses expected to be risked by the contractor, the potential risk of no recovery, and any expected long delay in recovery, CLIENTS and Counsel agree that a reasonable multiplier for Representation under this Agreement is four.

This is the method by which the contingent fee is computed under Tex. Govt. Code 2254.106 (a), (b), and (c).

2.05 There shall be no difference in the method by which the contingent fee is computed if the matter is settled, tried, or tried and appealed.

2.06 Litigation and other expenses including attorney's fees of opposing counsel, if unsuccessful, related to the Representation will be paid solely by COUNSEL as part of the contingent fee and will not be reimbursed by CLIENTS. CLIENTS will not be responsible to COUNSEL for the reimbursement of litigation and other expenses related to the Representation under any circumstances.

2.07 Any subcontracted legal or support services performed by a person who is not a contracting attorney, or a partner, shareholder, or employee of a contracting attorney or law firm is an expense subject to reimbursement only in accordance with Subchapter C, Chapter 2254 of the Texas Government Code. However, as indicated in Section 2.06, CLIENTS are not responsible for the reimbursement of litigation and other expenses under this Agreement.

2.08 The amount of the contingent fee and reimbursement of expenses under this Agreement will be paid and limited in accordance with Subchapter C, Chapter 2254 of the Texas Government Code. As indicated in Section 2.06, litigation and other expenses related to the Representation will be paid solely by COUNSEL and will not be reimbursed by CLIENTS.

2.09 In addition to the above, the payment of fees and expenses, as set forth herein, are subject to limitations established by TEX. GOV'T CODE § 2254.108.

C. Time and Expense Records

3.01 In accordance with Tex. Govt. Code. 2254.104(a), COUNSEL shall keep current and complete written time and expense records that describe in detail the time and money spent each day in performing the contract. In accordance with Tex. Govt. Code. 2254.104(b), COUNSEL shall permit the governing body or governing officer of each CLIENT, the attorney general, and the state auditor or the CLIENT'S auditor, as applicable, each to inspect or obtain copies of the time and expense records at any time on request. In accordance with Tex. Govt. Code 2254.104(c), on conclusion of the matter for which legal services were obtained, COUNSEL shall provide each CLIENT with a complete written statement that describes the outcome of the matter, states the amount of any recovery, shows COUNSEL's computation of the amount of the contingent fee and contains the final complete time and expense records by Tex. Govt. Code. 2254.104(a).

D. Joint Representation

4.01 COUNSEL has advised CLIENTS that COUNSEL may represent other clients ("Other Clients") with claims similar to those of CLIENTS. Further, COUNSEL has advised CLIENTS that there are important potential advantages and disadvantages to participating in joint representation in which COUNSEL represent multiple clients pursuing similar claims. CLIENTS consent to COUNSEL's joint representation of CLIENTS and such Other Clients.

E. Other Provisions

5.01 The term of this Agreement begins on the upon the date it is executed by the parties and continues until the Representation is concluded.

5.02 In accordance with Tex. Govt. Code. 2254.1038, this Agreement shall be of no force and effect until reviewed and approved by the Attorney General of the State of Texas.

5.03 To enable COUNSEL to provide effective representation, CLIENTS agree to do the following: (1) disclose to COUNSEL, fully and accurately and on a timely basis, all facts and documents within each CLIENT's knowledge that are or might be material or that COUNSEL may request, (2) keep COUNSEL apprised on a timely basis of all developments relating to the Representation that are or might be material, (3) attend meetings, conferences, and other proceedings when it is reasonable to do so, and (4) otherwise cooperate fully with COUNSEL. Finally, if CLIENTS have any concern or problem with COUNSEL, their attorneys or employees at any time, CLIENTS agree to immediately notify COUNSEL's lead attorney, Martin J. Phipps, about any concerns or problems and not wait until a later time.

5.04 None of the Parties shall assign, in whole or in part, any duty or obligation of performance under this Agreement without the express written permission of the other party, unless otherwise authorized in this Agreement.

5.05 Any notice required or permitted to be given to COUNSEL hereunder may be given by hand delivery, facsimile, email, or certified United States Mail, postage prepaid, return receipt requested, addressed to:

Martin J. Phipps
PHIPPS DEACON PURNELL pllc
the PHIPPS
102 9th Street
San Antonio, Texas 78215
Fax: (210) 340-9799
Email: mphipps@phippsdeaconpurnell.com

Any notice required or permitted to be given to Nueces County Appraisal District hereunder may be given by hand delivery, facsimile, email, or certified United States Mail, postage prepaid, return receipt requested, addressed to:

Ramiro "Ronnie" Canales
Chief Appraiser
Nueces County Appraisal District
201 N. Chaparral, Ste. 206
Corpus Christi, Texas 78401
Ph: (361)881-9978
Email: rcanales@nuecescad.net

Tom C. Wheat
General Counsel
Nueces County Appraisal District
101 N. Shoreline Blvd, Suite 201
Corpus Christi, Texas 78401
Ph: (361) 861-1103
Email: twheat@wheatlaw.com

Any notice required or permitted to be given to **Corpus Christi ISD** hereunder may be given by hand delivery, facsimile, email, or certified United States Mail, postage prepaid, return receipt requested, addressed to:

_____

_____

Any notice required or permitted to be given to **City of Corpus Christi** hereunder may be given by hand delivery, facsimile, email, or certified United States Mail, postage prepaid, return receipt requested, addressed to:

_____

_____

Any notice required or permitted to be given to **County of Nueces** hereunder may be given by hand delivery, facsimile, email, or certified United States Mail, postage prepaid, return receipt requested, addressed to:

_____

_____

Any notice required or permitted to be given to **Del Mar College** hereunder may be given by hand delivery, facsimile, email, or certified United States Mail, postage prepaid, return receipt requested, addressed to:

_____

_____

Any notice required or permitted to be given to **Nueces County Hospital District** hereunder may be given by hand delivery, facsimile, email, or certified United States Mail, postage prepaid, return receipt requested, addressed to:

_____

_____

Such notices shall be considered given and complete upon successful transmission or upon deposit in the United States Mail.

5.06 COUNSEL affirmatively consents to the disclosure of its email addresses that are provided to CLIENTS. This consent is intended to comply with the requirements of the Texas Public Information Act. TEX GOV'T CODE ANN. §552.137, *et seq.*, as amended, and shall survive termination of this Agreement. This consent shall apply to email addresses provided by COUNSEL and agents acting on COUNSEL's behalf and shall apply to any email address provided in any form for any reason whether related to this Agreement or otherwise.

5.07 This Agreement is public information under Chapter 552 of the Texas Govt. Code and may not be withheld from a requestor under Section 552.103 or any other exception from required disclosure.

5.07 At the conclusion of the Representation, COUNSEL will return to CLIENTS any documents that COUNSEL is specifically requested to return. As to any documents so returned, COUNSEL may elect to keep a copy of the documents in COUNSEL's stored files. CLIENTS own all final work product generated from the Representation.

5.08 This Agreement will be construed without regard to any presumption or rule requiring construction or interpretation against the party drafting same.

5.09 This Agreement shall be governed and interpreted under Texas substantive law and exclusive venue and jurisdiction of any lawsuit or claim arising out of or relating to this Agreement shall lie only in Nueces, Texas.

5.10 COUNSEL hereby verifies that it does not boycott Israel and will not boycott Israel during the term of this Agreement.

5.11 Each waiver in this Agreement is subject to the overriding and governing rule that it will be effective only if and to the extent that (1) it is not prohibited by applicable law and (2) applicable law neither provides for having bargained for and obtained it.

5.12 The parties may by mutual agreement amend or supplement this Agreement at any time and from time to time; provided that they must do so in writing, and such writing must be signed by CLIENTS and COUNSEL.

5.13 If any provision of this Agreement is held in whole or in part to be unenforceable, void, or voidable for any reason, then such provision will be modified to reflect the parties' intention and to make the provision enforceable. In the event that one or more provisions of this Agreement is held unenforceable, all remaining provisions of this Agreement that have not been determined by a court as being unenforceable, void, or voidable, shall remain in full force and effect.

Effective October _____, 2019.

Nueces County Appraisal District

By:_____ _____
Ramiro "Ronnie" Canales Date
Nueces County Chief Appraiser
201 N. Chaparral Street, Suite 206
Corpus Christi, Texas 78401
(361) 881-9978
Email: rcanales@nuecescad.net

By:_____ _____
Tom C. Wheat Date
General Counsel
101 N. Shoreline Blvd, Suite 201
Corpus Christi, Texas 78401
(361) 861-1103
Email: twheat@wheatlaw.com

Corpus Christi ISD

By:_____ _____
Date

County of Nueces

By:_____ _____
Barbara Canales Date
Nueces County Judge

By:_____ _____
Laura Garza Jimenez Date
Nueces County Attorney

By:_____ _____
Kevin Kieschnick Date
Nueces County Assessor/Tax Collector

Del Mar College

By:_____ _____
Date

Nueces County Hospital District

By:_____ _____
Date

PHIPPS DEACON PURNELL pllc

By:_____ 9/17/14
Martin J. Phipps, Managing Member/Owner Date
PHIPPS DEACON PURNELL pllc
102 9th Street
San Antonio, Texas 78215
(210) 340-9877
mphipps@phippsdeaconpurnell.com

APPROVED BY THE ATTORNEY GENERAL OF THE STATE OF TEXAS:

_____ _____
Attorney General or His Designee Date

Norrell Brokerage
Customs Broker • Freight Forwarder

August 5, 2019

Nueces County Hospital District
Jonny Hipp, Administrator/CEO
555 N. Carancahua Street, Ste. 950
Corpus Christi, Texas 78401

Re: Request for Foreign Trade Zone Concurrence Letter
Gulf Copper & Manufacturing Inc.

Dear Mr. Hipp:

I am acting on behalf of Gulf Copper & Manufacturing Inc., as their Foreign Trade Zone Consultant.

Gulf Copper & Manufacturing Inc. is a company located at 118 State Hwy 361. They have been working with US Customs and Border Protection on establishing their site as a Foreign Trade Zone (FTZ) area. The company plans to store foreign wind components at their site. They are expected to generate much economic development in Port Aransas, Texas and surrounding areas.

We would appreciate your support of Gulf Copper & Manufacturing Inc.'s application for Foreign Trade Zone status by returning a signed copy of a concurrence letter to Ms. Carol Rodriguez, FTZ Manager at the Port of Corpus Christi. I have attached a sample letter for your reference.

Thank you for your time and if you have any questions or concerns, please contact me at (361) 852-2836.

Regards,

Jennifer L. Norrell
Norrell Brokerage
On behalf of Gulf Copper & Manufacturing Inc.

CC: Burt Moorehouse, Gulf Copper & Manufacturing Inc.

P.O. Box 2792 • Corpus Christi, Texas 78403
Ph: (361) 852-2836 • Fax: (361) 852-0840