EXHIBIT A: COUNTY HEALTH CARE PROVIDER PARTICIPATION PROGRAM RULES AND PROCEDURES

Rule 1. Definitions. In these rules and procedures:

(a) "Mandatory payment" means a mandatory payment authorized under Chapter 300 of Subtitle D of Title 4 of the Texas Health & Safety Code.

(b) "Institutional health care provider" means a nonpublic hospital that provides inpatient hospital services.

(c) "Paying provider" means an institutional health care provider required to make a mandatory payment.

(d) "Program" means a county health care provider participation program authorized under Subtitle D of Title 4 of the Texas Health & Safety Code.

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

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

(b) The commissioners court may adopt an order authorizing a county to participate in the program, subject to the limitations provided by these rules and procedures.

(c) To the extent any provision or procedure under Chapter 300 Subtitle D of Title 4 of the Texas Health & Safety Code causes a mandatory payment to be ineligible for federal matching funds, the county may provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare and Medicaid Services.

Powers and Duties of Commissioners Court

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

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

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

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

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

General Financing Provisions

Rule 6. Hearing.

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

(b) Not later than the fifth day before the date of the hearing required under Rule 6(a), the county commissioners court shall publish notice of the hearing in a newspaper of general circulation in the county.

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

Rule 7. Depository.

(a) The county shall designate one or more banks located in the county as the depository for mandatory payments received by the county. A bank designated as a depository serves for two years or until a successor is designated.

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

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

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

(a) Each county that collects a mandatory payment shall create a local provider participation fund.

(b) The local provider participation fund of a county consists of:

(1) all revenue received by the county attributable to mandatory payments, including any penalties and interest attributable to delinquent payments;

(2) money received from the Health and Human Services Commission as a refund of an intergovernmental transfer from the county to the state for the purpose of providing the nonfederal share of Medicaid supplemental payment program payments, provided that the intergovernmental transfer does not receive a federal matching payment; and

(3) the earnings of the fund.

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

(1) fund intergovernmental transfers from the county to the state to provide the nonfederal share of Medicaid payments for:

(A) uncompensated care payments to nonpublic hospitals if those payments are authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315);

(B) uniform rate enhancements for nonpublic hospitals in the Medicaid managed care service area in which the county is located;

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

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

(2) pay the administrative expenses of the county solely for activities under these rules and procedures, including the collateralization of deposits;

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

(4) refund to paying hospitals the proportionate share of money that the county (a) receives from the Health and Human Services Commission that is not used to fund the nonfederal share of Medicaid supplemental payment program payments; or (b) determines cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments;

(5) transfer funds to the Health and Human Services Commission if the county is legally required by law to transfer the funds to address a disallowance of federal matching funds with respect to payments, rate enhancements, and reimbursements for which the county made intergovernmental transfers described by Subdivision (1); and

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

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

(e) An intergovernmental transfer of funds described by Rule 8(c)(1) and any funds received by the county as a result of an intergovernmental transfer described by that rule may not be used by the county or any other entity to expand Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 11 1-152).

Mandatory Payments

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

(a) Except as provided by Rule 11, the commissioners court of a county that collects a mandatory payment may require that a mandatory payment be assessed annually or periodically throughout the fiscal year at the discretion of the board on the net patient revenue of each institutional health care provider located in the county.

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

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

(d) The county shall update the amount of the mandatory payment on an annual basis.

Rule 10. Mandatory Payment Requirements

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

(b) The commissioners court of a county that collects a mandatory payment shall set the amount of the mandatory payment.

(c) Subject to the maximum amount prescribed by Rule 11(a), the commissioners court of a county that collects a mandatory payment shall set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the county for activities under these rules and procedures and to fund purposes described in Rule B(c).

(i) The annual amount of revenue from mandatory payments used for administrative expenses of the county for activities under these rules and procedures is $20,000, plus the cost of collateralization of deposits, regardless of actual expenses.

Rule 11. Mandatory Payment Prohibitions.

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

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

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

(d) If a county determines that administration of mandatory payments is increasing the costs of health care to the residents of the county, the commissioners court may rescind participation in the program and refund to each paying hospital the proportionate share of any money remaining in the local provider participation fund at the time the county's participation is rescinded.

Rule 12. Assessment and Collection of Mandatory Payments.

The county may collect or contract for the assessment and collection of mandatory payments.

Rule 13. Interest and Penalties.

Any interest and penalties on mandatory payments are governed by the law applicable to county ad valorem taxes. Discounts applicable to county ad valorem taxes do not apply.