

**TEXAS DEPARTMENT OF HEALTH
FINAL ADOPTION OF RULES FOR BOARD OF HEALTH APPROVAL
COVER MEMORANDUM**

July 2004

Agenda Item No: _____

Presenter: Kathryn C. Perkins
Bureau of Emergency Management

Summary:

These are final rules concerning the certification and licensure of emergency medical services (EMS) certificates, providers, EMS/Trauma systems funding, Do Not Resuscitate Orders and requirements for Automated External Defibrillator training. The repeals, amendments and new rules are the result of obsolete language and legislative changes in language and the Government Code, §2001.039, state-mandated four-year review of rules. The repeal and amended language aligns the rules with current state law and clarifies the requirements for meeting standards. These final rules will have a fiscal impact on local governments which provide EMS directly, providers, Texas Department of Health (TDH) trauma designated hospitals, hospital in “active pursuit of TDH trauma designation” and regional advisory councils.

The Board recommended publication of the proposed rules in April 2004. The proposed rules were published in the Texas Register on April 30, 2004.

Description of Stakeholder input during the public comment period:

The Governor’s EMS and Trauma Advisory Council (GETAC) reviewed draft rules of §§157.5 and 157.41 at the council’s meeting on August 29, 2003, in Austin, Texas, and unanimously voted to recommend proposal of the rules by the Board of Health. No additional comments from GETAC or the individual members have been received.

GETAC reviewed draft rules of §§157.25, 157.130 and 157.131 at the council’s meeting on February 13, 2004, in Austin, Texas, and unanimously voted to recommend proposal of the rules by the Board of Health. No additional comments from GETAC or the individual members have been received.

Comments Received:

The comments received were generally favorable and supported the adoption of rule language without change; however, some of the comments had specific concerns and/or offered suggestions for change. A summary of comments received and the department’s responses are provided in the attached adoption preamble.

Recommended Board Action:

Approve an order adopting the rules concerning the certification and licensure of emergency medical services (EMS) certificates, providers, EMS/Trauma systems funding, Do Not Resuscitate Orders and requirements for Automated External Defibrillator training to be effective 20 days after filing with the Texas Register Division, Office of the Secretary of State.

Title 25. Health Services
Part I. Texas Department of Health
Chapter 157. Emergency Medical Care
Subchapter A. Emergency Medical Services - Part A
New §157.5
Subchapter B. Emergency Medical Services Provider Licenses
Amendment §157.25
Subchapter C. Emergency Medical Services Training and Course Approval
Amendment §157.41
Subchapter G. Emergency Medical Services Trauma Systems
Repeal §157.130, New §§157.130, 157.131

Adoption Preamble

The Texas Department of Health (department) adopts amendments to §157.25, concerning Out of Hospital Do Not Resuscitate Orders and §157.41, concerning Automated External Defibrillators; repeal of §157.130, concerning the emergency medical services and trauma care system account; and new §157.5 concerning rule exception request for Emergency Medical Services (EMS) personnel and applicants for EMS certification or licensure; new §157.130, concerning the emergency medical services and trauma care system account and emergency medical services, trauma facilities, and trauma care system fund; and new §157.131, concerning the designated trauma facility and emergency medical services account. New §§157.130 and §157.131 are adopted with changes to the proposed text as published in the April 30, 2004, issue of the Texas Register (29 TexReg 4056) as a result of staff comments. New §157.5, amendments to §§157.25, 157.41 and the repeal of §157.130 are adopted without changes and will not be republished.

Specifically, the sections cover out of hospital Do Not Resuscitate Orders, minimum standards for Automated External Defibrillator training, rule exceptions requests for EMS personnel and applicants for EMS certification or licensure and funding formulas/eligibility criteria for the emergency medical services and trauma care system account and emergency medical services, trauma facilities, and trauma care system fund and the designated trauma facility and emergency medical services account.

Rule amendments regarding Out of Hospital Do Not Resuscitate Orders are required to further protect public health by improving the understanding of and clarification of the Do Not Resuscitate form for out of hospital providers and healthcare practitioners utilizing the form. Rule amendments concerning Automated External Defibrillators are required to further protect public health by creating minimum standards for Automated External Defibrillator training.

The repeal and new rule relating to emergency medical services and trauma care system account and emergency medical services, trauma facilities, and trauma care system fund are necessary to update, clarify, and comply with revisions to the Texas Health and Safety Code, Chapter 773, §773.006 and §773.122, pursuant to Senate Bill 1131 of the 78th Regular Session of the Texas Legislature, 2003. The new rule

concerning rule exception requests for Emergency Medical Services (EMS) personnel and applicants for EMS certification or licensure was necessary to update and clarify procedures for the department to grant exceptions for EMS personnel and EMS certificates. The new rule concerning the designated trauma facility and emergency medical services account complies with the creation of Texas Health and Safety Code, Chapter 780, pursuant to Senate Bill 1131 of the 78th Regular Session of the Texas Legislature, 2003.

Government Code, §2001.039, requires that each state agency review and consider for re adoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedures Act). The sections have been reviewed and the department has determined that reasons for adopting the sections continue to exist; however, revisions to the sections were necessary and described in this preamble. Authority for the board to propose and adopt rules in this section is found in the Health Safety Code, Chapter 773.

The department published a Notice of Intention to review and consider for re adoption, revision, or repeal Chapter 157, Subchapter B, Emergency Medical Services Provider Licenses, §157.25; Subchapter C, Emergency Medical Services Training and Course Approval, §157.41 and Subchapter G, Emergency Medical Services Trauma Systems, §157.130 in the September 12, 2003, issue of the Texas Register (28 TexReg 8013). There were no comments received due to the publication of the notice.

The department received eight public comments during the comment period.

Comment: Concerning §157.131(a)(11) and (13), one commentator requested that rule language be amended to more clearly define cost to charge ratio.

Response: The department agrees with the suggested comment. Language was deleted in §157.131(a)(11) and added to §157.131(a)(13) to clarify the department's intent. Identical language was also deleted in §157.130(a)(10) and added to §157.130(a)(12) to clarify the department's intent. No change was made as a result of the comment.

Comment: Concerning §157.131(a)(11), one commentator requested the insertion of rule language that would illustrate specific line numbers from the Medicaid cost report to be pulled.

Response: The department disagrees with the suggested comment because of the potential for these citations to change frequently. This information will be included in the application instructions. No change was made as a result of the comment.

Comment: Concerning §157.131(d)(5)(B), one commentator requested that the rule language be amended to reduce the number of notarized signatures required in the uncompensated trauma care application.

Response: The department disagrees with the suggested comment. The adopted rule language provides an added layer of accountability to ensure a hospital's uncompensated trauma care costs are accurately reported in its uncompensated trauma care application. No change was made as a result of the comment.

Comment: Concerning §157.131(e)(3), the Texas Medical Association and the Texas Orthopedic Association provided comment requesting that a new subsection be created to require hospitals to submit a report to the department, upon request, outlining the aggregate amount of money a hospital distributes to trauma physicians by specialty for uncompensated trauma care.

Response: The department disagrees with the suggested amendment to the rule language. Under §157.131(e)(3), a hospital is reimbursed for uncompensated trauma care previously provided by the hospital. The hospital's charges and costs are attested to through the department's application process. Before receiving monies, a hospital will have already provided sufficient documentation to the department that it has already provided uncompensated care. The department believes that an additional required detailed report to the state of how the hospital expended its reimbursements from §157.131(e)(3) would be an undue burden. No changes were made as a result of the comments.

Comment: Concerning §157.131(e)(3)(G), the Harris County Medical Society, Texas Association of Neurological Surgeons, Texas Orthopedic Association and Texas Medical Association provided comments requesting the following amending language: Hospitals shall have a physician incentive plan that supports the facility's participation in the trauma system.

Response: The department disagrees with the suggested amendment to language. After careful consideration of all public comment regarding §157.131, subsection (e)(3)(G), the department concluded that it would be more flexible and equitable for physician compensation contracts to be negotiated at local levels rather than being mandated by rule. The adopted rule language encourages hospitals to compensate its physicians in a manner that supports the facility's participation in the trauma system. Additionally, the current proposed language adheres to legislation author's, Representative Dianne Delisi, letter of legislative intent, dated December 2, 2003, addressed to Commissioner Sanchez stating that physician reimbursement is a local issue and that House Bill 3588 of the 78th Session of the Texas Legislature, 2003, was not intended to require physician reimbursement agreements. No changes were made as a result of the comments.

The department made the following changes due to staff comments along with minor editorial changes.

Change: Concerning §§157.130(a)(9) and 157.131(a)(9), in order to clarify the intent and improve the accuracy of the section, the verbiage "or discharged from the hospital" was removed from the definition of "Operative intervention". Deleting the verbiage clarifies and improves the accuracy of the definition.

Change: Concerning §157.130(e)(3), in order to clarify the intent and simplify the distributions of funds outlined in the subsection, a new subparagraph (D) was inserted into the rule, providing the department the option to distribute funds outlined in the subsection in conjunction with the distribution of funds outlined in §157.131(e)(2) concerning the hospital allocation of the designated trauma facility and emergency medical services account.

Four organizations provided comments that were in favor of the rules overall except for the language

“Hospitals shall have a physician incentive plan that supports the facility’s participation in the trauma system”. Two organizations suggested that we create a new subsection that would require hospitals to report additional information to the department. Two individuals and one organization provided comments that were in favor of adopting the rules proposed at the April 15, 2004, Board of Health Meeting without change. One commenter was neither for nor against the rules in their entirety, but suggested changes for clarification. The remaining comments were from staff.

The amendments, repeal and new rules are adopted under the Texas Health and Safety Code, Chapter 773, Emergency Medical Services, which provides the Board of Health (board) with the authority to adopt rules to implement the Emergency Medical Services Act; and §12.001, which provides the Board with the authority to adopt rules for its procedure and for the performance of each duty imposed by law on the board, the department or the commissioner of health. The review of the rules implements Government Code, §2001.039.

Repeal.

§157.130. Emergency Medical Services and Trauma Care System Account.

Legend: (New Rules- No changes from proposed version)

Regular Print = Final language, same as proposed, for final adoption

§157.5. Rule Exemption Requests. (New)

(a) EMS personnel and applicants for EMS certification or licensure may request an exemption to rules of this title by:

(1) submitting an exemption request application form with a nonrefundable fee of \$30, if applicable, in addition to any other applicable applications and fees required by this title;

(2) providing a letter of explanation and other documented evidence which establishes that patient care will not be diminished, or the health and safety of the public affected, if the exemption is approved;

(3) providing a signed and dated written statement of support from the medical director of the licensed emergency medical services (EMS) provider or registered first responder organization with whom the applicant is affiliated or will be affiliated; and

(4) providing a written plan under which the applicable requirement will be met as soon as possible.

(b) In determining whether to grant the exemption, the bureau chief shall take into consideration the best interests of the people in a rural area who are served by the licensed EMS provider or registered first responder organization with whom the applicant is affiliated or will be affiliated, if approved. For the purposes of this section, a rural area is defined to be:

(1) a county of 50,000 or less; or

(2) a sparsely populated area in a county with a population of more than 50,000, as determined by the Federal Office of Rural Health Policy designation (of rural areas within metropolitan areas).

(c) If the request is approved, an exemption may be granted temporarily. The applicant will be notified by the bureau chief, in writing, and the notification shall include:

(1) the date the exemption begins and expires;

(2) an explicit statement which specifically describes the rule requirements exempted and any related conditions which must be met for the exemption to apply or continue to apply.

(d) This exemption process may be utilized to temporarily allow a person in a rural area, described in subsection (b)(1) and (2) of this subsection, to practice at a higher level prior to receiving the higher level of certification.

(1) To apply to receive this allowance for up to two months after course completion,

the applicant must:

- (A) meet the requirements of subsection (a)(1) - (4) of this section;
- (B) be currently certified by the department as an ECA, EMT, or EMT-Intermediate; and
- (C) submit a course completion certificate for the higher level of training.

(2) If granted through written approval from the bureau chief, the candidate may practice at the higher level only if accompanied by an individual who is certified or licensed by the department at the same or a higher level of certification or licensure.

(3) This allowance shall be automatically and immediately forfeited upon notification of the candidate's failure of the National Registry written or practical examination.

Legend: (Final Amendments – No additional changes from proposed version)

Regular Print = Current language

No change = No changes are being considered for the designated subdivision

157.25. Out-of-Hospital Do Not Resuscitate (DNR) Order. (Amendment)

(a) Purpose. The purpose of this section shall be to establish a statewide DNR protocol as required in the Health and Safety Code, Title 2, Chapter 166.

(b) DNR order. A DNR order may be issued by an attending physician for any patient. That attending physician has responsibility for ensuring that the form is filled out in its entirety and that the information regarding the existence of a DNR order is entered into the patient's medical record.

(c) Protocol development. A DNR protocol in accordance with this section, shall apply to all out-of-hospital settings including cardiac arrests which occur during interfacility transport. The protocol shall include the following:

(1) a copy of the Texas Department of Health (department) standardized DNR form listing the designated treatments that shall be withdrawn or withheld. Those treatments shall be:

- (A) cardiopulmonary resuscitation;
- (B) advanced airway management;
- (C) artificial ventilation;
- (D) defibrillation; and
- (E) transcutaneous cardiac pacing.

(2) an explanation of the patient identification process to include an option to use a department-standardized identification device such as a necklace or bracelet; and

(3) an on-site DNR dispute resolution process which includes contacting an appropriate physician.

(d) Recordkeeping. Records shall be maintained on each incident in which an out-of-hospital DNR order or DNR identification device is encountered by responding healthcare professionals, and the number of cases where there is an on-site revocation of the DNR order shall be recorded.

(1) The data documented should include:

(A) an assessment of patient's physical condition;

(B) whether an identification device or a DNR form was used to confirm DNR status and patient identification number;

(C) any problems relating to the implementation of the DNR order;

(D) the name of the patient's attending physician; and

(E) the full name, address, telephone number, and relationship to patient of any witness used to identify the patient.

(2) These records must be maintained and shall meet records retention requirements for each health care profession.

(3) If the patient is transported, the original DNR order or a copy of the original order will be kept with the patient.

(4) Copies of the original DNR order may be put on file with concerned parties, and the original order shall remain in the possession of the patient, a legal guardian, or the healthcare facility responsible for the patient's care.

(e) Out-of-state DNR Orders. Personnel may accept an out-of-hospital DNR order or device that has been executed in any other state, if there is no reason to question the authenticity of the order or device.

(f) Failure to honor a DNR order. If there are any indications of unnatural or suspicious circumstances, the provider shall begin resuscitation efforts until such time as a physician directs otherwise.

(g) Pregnant persons. A person may not withhold the designated treatments listed in subsection (c)(1) from a person known by responding healthcare professionals to be pregnant.

(h) DNR Form. The Bureau of Emergency Management or their appointees shall furnish DNR forms to physicians, clinics, hospitals, nursing homes, hospices and home health agencies throughout the state upon request.

(1) The form shall contain all the information as prescribed in the Health and Safety Code, Chapter 166.

(2) The form shall be 8-1/2 inches by 11 inches, printed front and back, and in the format specified by the board as follows.

Figure: 25 TAC §157.25(h)(2) (No change.)

(i) Identification devices. As an optional means of identification, a patient may obtain, at patient's expense, an Out-of-Hospital (OOH) DNR device. An OOH DNR device, as approved by the Texas Department of Health, must meet the following requirements:

(1) An intact, unaltered, easily identifiable plastic identification OOH DNR bracelet, with the word "Texas" (or a representation of the geographical shape of Texas and the word "STOP" imposed over the shape) and the words "Do Not Resuscitate", shall be honored by qualified EMS personnel in lieu of an original OOH DNR Order form.

(2) An intact, unaltered, easily identifiable metal bracelet or necklace inscribed with the words, "Texas Do Not Resuscitate - OOH" shall be honored by qualified EMS personnel in lieu of an OOH DNR Order form.

(3) The person or entity who provides an OOH DNR identification device to an individual shall send with the identification device a statement with the words, "Pursuant to Texas Health and Safety Code, §166.090 this identification device may only be worn by a person who has executed a valid out-of-hospital DNR order."

§157.41. Automated External Defibrillators. (Amendment)

(a) Purpose. The purpose of this rule is to establish minimum standards and requirements for training of persons using automated external defibrillators (AED).

(b) Exemption. This section shall not apply to persons who are licensed, certified or registered under the Texas Health and Safety Code, Chapter 773.

(c) Definitions.

(1) Automated External Defibrillator (AED) - An electronic medical device approved by the United States Food and Drug Administration which is capable of recognizing the presence or absence of cardioventricular fibrillation or rapid cardioventricular tachycardia; is capable of determining, without interpretation of cardiac rhythm by an operator, whether defibrillation should be performed and, on determining that defibrillation should be performed, automatically charges and requests the operator to deliver an electrical impulse to an individual's heart.

(2) Cardiopulmonary Resuscitation (CPR) - A life saving procedure involving closed chest compressions and artificial respiration to an individual who is pulseless and apneic or who is experiencing agonal respiration.

(d) Training required. A person acquiring and/or using an AED shall successfully complete a training course in CPR and AED operation in accordance with the guidelines established by the device's manufacturer and as approved by the American Heart Association, the American Red Cross, other nationally recognized associations, or the medical director of the local emergency medical services provider. The person shall maintain that training in accordance with the guidelines established by the training association.

(e) Notification required. A person or entity that acquires an AED shall immediately notify all local emergency medical service providers of the existence, physical location and type of device.

(f) Guidelines and procedures for use. Use of an AED shall be in accordance with the guidelines established as nationally recognized standards and shall be in accordance with the manufacturer's operating procedures.

Legend: (New Rules – With changes to proposed version)

Double underline = New language not proposed

[Bold, underline and brackets] = Proposed new language now being deleted

Regular print = Final language, same as proposed for final adoption

§157.130. Emergency Medical Services and Trauma Care System Account and Emergency Medical Services, Trauma Facilities, and Trauma Care System Fund. (New)

(a) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Extraordinary emergency--An event or situation which may disrupt the services of an EMS/trauma system.

(2) Rural county--A county with a population of less than 50,000 based on the latest official federal census population figures.

(3) Urban county--A county with a population of 50,000 or more based on the latest official federal census population figures.

(4) Emergency transfer--Any immediate transfer of an emergent or unstable patient, ordered by a licensed physician, from a health care facility to a health care facility which has the capability of providing a higher level of care or of providing a specialized type of care not available at the transferring facility.

(5) Trauma care --Care provided to patients who underwent treatment specified in at least one of the following ICD-9 (International Classification of Diseases, 9th Revision, of the National Center of

Health Statistics) codes: between 800.00 and 959.9, including 940.0-949.0 (burns), excluding 905.0-909.0 (late effects of injuries), 910.0-924.0 (blisters, contusions, abrasions, and insect bites), 930.0 – 939.0 (foreign bodies), and who underwent an operative intervention as defined in paragraph (9) of this subsection or was admitted as an inpatient for greater than 23-hours or who died after receiving any emergency department evaluation or treatment or was dead on arrival to the facility or who transferred into or out of the hospital.

(6) Uncompensated trauma care--The sum of “charity care” and “bad debt” resulting from trauma care as defined in paragraph (5) of this subsection after due diligence to collect. Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor (to include but not limited to Medicaid, Medicare, Children’s Health Insurance Program (CHIP), etc.) is not uncompensated trauma care.

(7) Charity care--The unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person classified by the hospital as “financially indigent” or “medically indigent”.

(A) Financially indigent--An uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital’s eligibility system.

(B) Medically indigent--A person whose medical or hospital bills after payment by third-party payors (to include but not limited to Medicaid, Medicare, CHIP, etc.) exceed a specified percentage of the patient’s annual gross income, determined in accordance with the hospital’s eligibility system, and the person is financially unable to pay the remaining bill.

(8) Bad debt--The unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person who is financially unable to pay, in whole or in part, for the services rendered and whose account has been classified as bad debt based upon the hospital’s bad debt policy. A hospital’s bad debt policy should be in accordance with generally accepted accounting principles.

(9) Operative intervention --Any surgical procedure resulting from a patient being taken directly from the emergency department to an operating suite regardless of whether the patient was admitted to the hospital **[or discharged from the hospital]**.

(10) Calculation of the costs of uncompensated trauma care--For the purposes of this section, a hospital will calculate its total costs of uncompensated trauma care by summing its charges related to uncompensated trauma care as defined in paragraph (6) of this subsection, then applying the cost to charge ratio defined in paragraph (12) of this subsection and derived in accordance with generally accepted accounting principles. **[The calculation of cost to charge ratios shall be based on the most recently completed and audited prior fiscal year of the hospital or hospital system.]**

(11) County of licensure --The County within which lies the location of the business mailing address of a licensed ambulance provider, as indicated by the provider on the application for

licensure form that it filed with the department.

(12) Cost-to-charge ratio -- A Hospital's overall cost-to-charge ratio **[, as]** determined by the Health and Human Services Commission from the hospital's [its] Medicaid cost report **[it submitted for its fiscal year ending in the previous calendar year]**. The hospital's latest available cost-to-charge ratio shall [Medicaid cost report will] be used to calculate its uncompensated trauma care costs [in the absence of the cost report for the hospital fiscal year ending in the previous calendar year].

(b) Reserve. On September 1 of each year, there shall be a reserve of \$500,000 in the emergency medical services (EMS) and trauma care system account and the emergency medical services, trauma facilities, and trauma care system fund (accounts) for extraordinary emergencies. During the fiscal year, distributions may be made from the reserve by the commissioner of health based on requests which demonstrate need and impact on the EMS and trauma care system (system). Proposals not immediately recommended for funding will be reconsidered at the end of each fiscal year, if funding is available, and need are still present.

(c) Allotments. The EMS allotment shall be 50%, the trauma service area (TSA) allotment shall be not more than 20%, and the uncompensated care allotment shall be at least 27% of the funds remaining from the accounts after any amount necessary to maintain the extraordinary emergency reserve of \$500,000 has been deducted.

(1) Allotment Determination. Each year, the department shall determine:

(A) eligibility of all EMS providers, regional advisory councils (RACs), and trauma facilities;

(B) the amount of the TSA allotment, the EMS allotment, and the uncompensated care allotment;

(C) each county's share of the EMS allotment for eligible recipients in the county;

(D) each RAC's share of the TSA allotment; and

(E) each designated trauma facility's share of the uncompensated care allotment.

(2) EMS Allotment. The department shall contract with each eligible RAC to distribute the county shares of the EMS allotment to eligible EMS providers based within counties which are aligned within the relevant RAC. Prior to distribution of the county shares to eligible providers, the RAC shall submit a distribution proposal, approved by the RAC's voting membership, to the department for approval.

(A) The county portion of the EMS allotment shall be distributed directly to eligible recipients without any reduction in the total amount allocated by the department and shall be used as an

addition to current county EMS funding of eligible recipients, not as a replacement.

(B) The department shall evaluate each RAC's distribution plan based on the following:

(i) fair distribution process to all eligible providers, taking into account all eligible providers participating in contiguous TSAs;

(ii) needs of the EMS providers; and

(iii) evidence of consensus opinion for eligible entities.

(C) A RAC opting to use a distribution plan from the previous fiscal year shall submit, to the department, a letter or email of intent to do so.

(D) Eligible EMS providers may opt to pool funds or contribute funds for a specified RAC purpose.

(3) TSA Allotment. The department shall contract with each eligible RAC to distribute the TSA allotment. Prior to distribution of the TSA allotment, the RAC shall submit a budget proposal to the department for approval. The department shall evaluate each RAC's budget according to the following:

(A) budget reflects all funds received by the RAC, including funds not expended in the previous fiscal year;

(B) budget contains no ineligible expenses;

(C) appropriate mechanism is used by RAC for budgetary planning; and

(D) program areas receiving funding are identified by budget categories.

(4) Uncompensated Care Allotment. The department shall contract with each eligible RAC to distribute shares of the uncompensated care allotment to eligible designated trauma facilities within the RAC's TSA. Prior to distribution of the uncompensated care allotment, the RAC shall submit a distribution proposal, approved by the RAC's voting membership, to the department for approval.

(A) The department shall evaluate each RAC's distribution plan based on the following:

(i) fair distribution process to all eligible providers;

(ii) needs of designated trauma facilities; and

(iii) evidence of consensus opinion from eligible entities.

(B) A RAC opting to use a distribution plan from the previous fiscal year shall submit, to the department, a letter or email of intent to do so.

(C) Eligible designated hospitals may opt to pool funds or contribute funds for a specified RAC purpose for novel or innovative projects.

(d) Eligibility requirements. To be eligible for funding from the accounts, all potential recipients (EMS Providers, RACs, Registered First Responder Organizations and hospitals) must maintain active involvement in regional system development. Potential recipients must also meet requirements for reports of expenditures from the previous year and planning for use of the funding in the upcoming year.

(1) Extraordinary Emergency Funding. To be eligible to receive extraordinary emergency funding, an entity must:

(A) be a licensed EMS provider, a licensed general hospital, or a registered first responder organization;

(B) submit to the department a signed written request, containing the entity name, contact information, amount of funding requested, and a description of the extraordinary emergency; and

(C) timely submit a signed and fully completed extraordinary emergency information checklist (on the department's form) to the department.

(2) EMS Allotment. To be eligible for funding from the EMS allotment, an EMS provider must meet the following requirements:

(A) maintain provider licensure as described in §157.11 of this title (relating to Requirements for An EMS Provider License) and provide emergency medical services and/or emergency transfers;

(B) demonstrate utilization of the RAC regional protocols regarding patient destination and transport in all TSAs in which they operate (verified by each RAC);

(C) demonstrate active participation in the regional system performance improvement (PI) program in all TSAs in which they operate (verified by each RAC);

(D) if an EMS provider is licensed in a county or contracted to provide emergency medical services in a county that is contiguous with a neighboring TSA, it must participate on at least one RAC of the TSAs:

(i) participation on both RACs is encouraged;

(ii) RAC participation shall follow actual patient referral patterns;

(iii) an EMS provider, contracted to provide emergency medical

services within a county of any one TSA and whose county of licensure is another county not in or contiguous with that TSA, must be an active member of the RAC for the TSA of their contracted service area and meet that RAC's definition of participation and requirements listed in subparagraph (E)(i)-(vi) of this paragraph; and

(iv) it is the responsibility of an EMS provider to contact each RAC in which it operates to ensure knowledge of the provider's presence and potential eligibility for funding from the EMS allotment related to that RAC's TSA;

(E) if an EMS provider is serving any county beyond its county of licensure it must provide to the department evidence of a contract or letter of agreement with each additional county government or taxing authority in which service is provided:

(i) inter-facility transfer letters of agreement and/or contracts, as well as mutual aid letters of agreement and/or contracts, do not meet this requirement;

(ii) contracts or letters of agreement must be dated and submitted to the department on or before August 31 of the respective year, and be effective more than six months of the upcoming fiscal year;

(iii) effective dates of the contracts or letters of agreement should be provided;

(iv) EMS providers with contracts or letters of agreement on file with the department which include contract service dates that meet the required time period need not resubmit.

(v) EMS providers are responsible for assuring that all necessary portions of their contracts and letters of agreement have been received by the department; and

(vi) air ambulance providers must meet the same requirements as ground transport EMS providers to be eligible to receive funds from a specific county other than the county of licensure; and

(F) if an EMS provider is licensed in a particular county and has a contract (with a county government or taxing authority) for a service area which is a geopolitical subdivision (examples listed below) whose boundary lines cross multiple county lines, it will be considered eligible for the 911 EMS Allotment for all counties overlapped by that geopolitical subdivision's boundary lines. A contract with every county that composes the geopolitical subdivision is not necessary. And, the eligibility of EMS providers, whose county of licensure is in a geopolitical subdivision other than those listed in clauses (i) – (vi) of this subparagraph, will be evaluated on a case-by-case basis.

(i) Municipalities.

(ii) School districts.

(iii) Emergency service districts (ESDs).

(iv) Hospital districts.

(v) Utility districts.

(vi) Prison districts.

(3) RAC Allotment. To be eligible for funding from the RAC allotment, a RAC must:

(A) be officially recognized by the department as described in §157.123 of this title (relating to Regional Emergency Medical Services/Trauma Systems);

(B) be incorporated as an entity that is exempt from federal income tax under §501(a) of the United States Internal Revenue Code of 1986, and its subsequent amendments, by being listed as an exempt organization under §501(c)(3) of the code;

(C) submit documentation of ongoing system development activity and future planning;

(D) have demonstrated that a regional system performance improvement (PI) process is ongoing by submitting to the department the following:

(i) lists of committee meeting dates and attendance rosters for the RAC'S most recent fiscal year;

(ii) committee membership rosters which included each member's organization or constituency; and

(iii) lists of issues being reviewed in the system performance improvement meetings; and

(E) submit all required EMS allocation eligibility items addressed in paragraph (2)(B) - (C) of this subsection.

(4) To be eligible to distribute the EMS, Uncompensated Care and TSA allotments, a RAC must be incorporated as an entity that is exempt from federal income tax under §501(a) of the Internal Revenue Code of 1986, and its subsequent amendments, by being listed as an exempt organization under §501(c)(3) of the code.

(5) Uncompensated Care Allotment. To be eligible for funding from the Uncompensated Care allotment, a hospital must be a department designated trauma facility or a Department of Defense hospital that is a department designated trauma facility.

(A) To receive funding from the Uncompensated Care allotment, an application must be submitted within the time frame specified by the department and include the following:

(i) name of facility;

(ii) location of facility including mailing address, city and county; and

(iii) Texas Provider Identifier (TPI number) or accepted federal identification number.

(B) The application must be signed and sworn to before a Texas Notary Public by the chief financial officer, chief executive officer and the chairman of the facility's board of directors.

(C) A copy of the application shall be distributed by Level I, II, or III facilities to the trauma medical director and Level IV facilities to the physician director.

(D) The department may opt to use data from applications submitted by qualified hospitals in accordance with §157.131(d)(5) of this title (relating to Designated Trauma Facility and Emergency Medical Services Account) for the distribution of funds outlined in subsection (e)(3) of this section.

(E) Additional information may be requested at the department's discretion.

(e) Calculation Methods. Calculation of county shares of the EMS allotment, the RAC shares of the TSA allotment, and the TSA's share of the uncompensated care allotment.

(1) EMS allotment.

(A) Counties will be classified as urban or rural based on the latest official federal census population figures.

(B) The EMS allotment will be derived by adjusting the weight of the statutory criteria in such a fashion that, in so far as possible, 40% of the funds are allocated to urban counties and 60% are allocated to rural counties.

(C) An individual county's share of the EMS allotment shall be based on its geographic size, population, and number of emergency health care runs multiplied by adjustment factors, determined by the department, so the distribution approximates the required percentages to urban and rural counties.

(D) The formula shall be: ((the county's population multiplied by an adjustment factor) plus (the county's geographic size multiplied by an adjustment factor) plus (the county's total emergency health care runs multiplied by an adjustment factor) divided by 3) multiplied by (the total EMS allocation). The adjustment factors will be manipulated so that the distribution approximates the required percentages to urban and rural counties. Total emergency health care runs shall be the number of emergency runs electronically transmitted to the department in a given calendar year by EMS providers.

(2) TSA allotment.

(A) A RAC's share of the TSA allotment shall be based on its relative geographic size, population, and trauma care provided as compared to all other TSAs.

(B) The formula shall be: ((the TSA's percentage of the state's total population) plus (the TSA's percentage of the state's total geographic size) plus (the TSA's percentage of the state's total trauma care) divided by 3)) multiplied by (the total TSA allotment). Total trauma care shall be the number of trauma patient records electronically transmitted to the department in a given calendar year by EMS providers and hospitals.

(3) Uncompensated care allotment.

(A) The uncompensated care allotment shall be based on a TSA's relative geographic size, population, and a TSA's percentage of the state's total reported uncompensated trauma care.

(B) The formula shall be: ((the TSA's percentage of the state's total population) plus (the TSA's percentage of the state's total geographic size) plus (the TSA's percentage of the total reported cost of uncompensated trauma care by qualified hospitals that year) divided by 3) multiplied by [the total uncompensated care allotment).

(C) For purposes of subparagraphs (A)-(B) of this paragraph, the reporting period of a facility's uncompensated trauma care shall apply to costs incurred during the preceding calendar year.

(D) The department may choose to distribute funds outlined in paragraph (3) of this subsection, to eligible recipients, in conjunction with the distribution of funds outlined in §157.131(e)(2) of this title concerning the hospital allocation of the designated trauma facility and emergency medical services account.

(f) Loss of funding eligibility. If the department finds that an EMS provider, RAC, or trauma facility has violated the Health and Safety Code, §773.122, or fails to comply with this section, the department may withhold account monies for a period of one to three years depending upon the seriousness of the infraction.

§157.131. Designated Trauma Facility and Emergency Medical Services Account. (New)

(a) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Extraordinary emergency--An event or situation which may disrupt the services of an EMS/trauma system.

(2) Rural county--A county with a population of less than 50,000 based on the latest official federal census population figures.

(3) Urban county--A county with a population of 50,000 or more based on the latest official federal census population figures.

(4) Emergency transfer—Any immediate transfer of an emergent or unstable patient, ordered by a licensed physician, from a health care facility to a health care facility which has the capability of providing a higher level of care or of providing a specialized type of care not available at the transferring facility.

(5) Trauma care --Care provided to patients who underwent treatment specified in at least one of the following ICD-9 (International Classification of Diseases, 9th Revision, of the National Center of Health Statistics) codes: between 800.00 and 959.9, including 940.0-949.0 (burns), excluding 905.0-909.0 (late effects of injuries), 910.0-924.0 (blisters, contusions, abrasions, and insect bites), 930.0 – 939.0 (foreign bodies), and who underwent an operative intervention as defined in paragraph (9) of this subsection or was admitted as an inpatient for greater than 23-hours or who died after receiving any emergency department evaluation or treatment or was dead on arrival to the facility or who transferred into or out of the hospital.

(6) Uncompensated trauma care--The sum of “charity care” and “bad debt” resulting from trauma care as defined in (a)(5) of this section after due diligence to collect. Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor (to include but not limited to Medicaid, Medicare, Children’s Health Insurance Program (CHIP), etc.) is not uncompensated trauma care.

(7) Charity care--The unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person classified by the hospital as “financially indigent” or “medically indigent”.

(A) Financially indigent-- An uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital’s eligibility system.

(B) Medically indigent-- A person whose medical or hospital bills after payment by third-party payors (to include but not limited to Medicaid, Medicare, CHIP, etc.) exceed a specified percentage of the patient’s annual gross income, determined in accordance with the hospital’s eligibility system, and the person is financially unable to pay the remaining bill.

(8) Bad debt--The unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person who is financially unable to pay, in whole or in part, for the services rendered and whose account has been classified as bad debt based upon the hospital’s bad debt policy. A hospital’s bad debt policy should be in accordance with generally accepted accounting principles.

(9) Operative intervention –Any surgical procedure resulting from a patient being taken directly from the emergency department to an operating suite regardless of whether the patient was

admitted to the hospital **[or discharged from the hospital]**.

(10) Active pursuit of department designation as a trauma facility -- means that by December 31, 2003, a licensed hospital, applying for a designation from the department as a trauma facility, must have submitted:

(A) a complete application to the department's trauma facility designation program or appropriate agency for trauma verification;

(B) evidence of participation in Trauma Services Area (TSA) Regional Advisory Council (RAC) initiatives;

(C) evidence of a hospital trauma performance improvement committee; and

(D) data to the department's EMS/Trauma Registry.

(11) Calculation of the costs of uncompensated trauma care -- For the purposes of this section, a hospital will calculate its total costs of uncompensated trauma care by summing its charges related to uncompensated trauma care as defined in paragraph (6) of this subsection, then applying the cost to charge ratio defined in paragraph (13) of this subsection and derived in accordance with generally accepted accounting principles. **[The calculation of cost to charge ratios shall be based on the most recently completed and audited prior fiscal year of the hospital or hospital system.]**

(12) County of licensure – The County within which lies the location of the business mailing address of a licensed ambulance provider, as indicated by the provider on the application for licensure form that it filed with the department.

(13) Cost-to-charge ratio – A Hospital's overall cost-to-charge ratio **[, as]** determined by the Health and Human Services Commission from the hospital's [its] Medicaid cost report **[it submitted for its fiscal year ending in the previous calendar year]**. The hospital's latest available cost-to-charge ratio shall **[Medicaid cost report will]** be used to calculate its uncompensated trauma care costs **[in the absence of the cost report for the hospital fiscal year ending in the previous calendar year]**.

(b) Reserve. On September 1 of each year, there shall be a reserve of \$500,000 in the designated trauma facility and emergency medical services account (account) for extraordinary emergencies. During the fiscal year, distributions may be made from the reserve by the commissioner of health based on requests which demonstrate need and impact on the EMS and trauma care system (system). Proposals not immediately recommended for funding will be reconsidered at the end of each fiscal year, if funding is available, and a need is still present.

(c) Allocations. The EMS allocation shall be not more than 2%, the TSA allocation shall be not more than 1%, and the hospital allocation shall be at least 96% of the funds appropriated from the account after any amount necessary to maintain the extraordinary emergency reserve of \$500,000 has been deducted.

(1) Allocation Determination. Each year, the bureau of emergency management (department) shall determine:

(A) eligible recipients for the EMS allocation, TSA allocation, and hospital allocation;

(B) the amount of the TSA allocation, the EMS allocation, and the hospital allocation;

(C) each county's share of the EMS allocation for eligible recipients in the county;

(D) each RAC's share of the TSA allocation; and

(E) each facility's share of the hospital allocation.

(2) EMS Allocation. The department shall contract with each eligible RAC to distribute the county shares of the EMS allocation to eligible EMS providers based within counties which are aligned within the relevant RAC. Prior to distribution of the county shares to eligible providers, the RAC shall submit a distribution proposal, approved by the RAC's voting membership, to the department for approval.

(A) The county portion of the EMS allocation shall be distributed directly to eligible recipients without any reduction in the total amount allocated by the department and shall be used as an addition to current county EMS funding of eligible recipients, not as a replacement.

(B) The department shall evaluate each RAC's distribution plan based on the following:

(i) fair distribution process to all eligible providers, taking into account all eligible providers participating in contiguous TSAs;

(ii) needs of the EMS providers; and

(iii) evidence of consensus opinion for eligible entities.

(C) A RAC opting to use a distribution plan from the previous fiscal year shall submit, to the department, a letter or email of intent to do so.

(D) Eligible EMS providers may opt to pool funds or contribute funds for a specified RAC purpose.

(3) TSA Allocation. The department shall contract with eligible RACs to distribute the TSA allocation. Prior to distribution of the TSA allocation, the RAC shall submit a budget proposal to the department for approval. The department shall evaluate each RAC's budget according to the

following:

(A) budget reflects all funds received by the RAC, including funds not expended in the previous fiscal year;

(B) budget contains no ineligible expenses;

(C) appropriate mechanism is used by RAC for budgetary planning; and

(D) program areas receiving funding are identified by budget categories.

(4) Hospital Allocation. The department shall distribute funds directly to facilities eligible to receive funds from the hospital allocation to subsidize a portion of uncompensated trauma care provided or to fund innovative projects to enhance the delivery of patient care in the overall EMS/Trauma System. Funds distributed from the hospital allocations shall be made based on, but not limited to:

(A) the percentage of the hospital's uncompensated trauma care cost in relation to total uncompensated trauma care cost reported by qualified hospitals that year; and

(B) availability of funds.

(d) Eligibility requirements. To be eligible for funding from the account, all potential recipients (EMS Providers, RACs, Registered First Responder Organizations and hospitals) must maintain active involvement in regional system development. Potential recipients also must meet requirements for reports of expenditures from the previous year and planning for use of the funding in the upcoming year.

(1) Extraordinary Emergency Funding. To be eligible to receive extraordinary emergency funding, an entity must:

(A) be a licensed EMS provider, a licensed hospital, or a registered first responder organization;

(B) submit to the department a signed written request, containing the entity name, contact information, amount of funding requested, and a description of the extraordinary emergency; and

(C) timely submit a signed and fully completed extraordinary emergency information checklist (on the department's form) to the department.

(2) EMS Allocation. To be eligible for funding from the EMS allocation an EMS provider must meet the following requirements:

(A) maintain provider licensure as described in §157.11 of this title and provide emergency medical services and/or emergency transfers;

(B) demonstrate utilization of the RAC regional protocols regarding patient destination and transport in all TSAs in which they operate (verified by each RAC);

(C) demonstrate active participation in the regional system performance improvement (PI) program in all TSAs in which they operate (verified by each RAC);

(D) if an EMS provider is licensed in a county or contracted to provide emergency medical services in a county that is contiguous with a neighboring TSA, it must participate on at least one RAC of the TSAs:

(i) participation on both RACs is encouraged;

(ii) RAC participation shall follow actual patient referral patterns;

(iii) an EMS provider contracted to provide emergency medical services within a county of any one TSA and whose county of licensure is another county not in or contiguous with that TSA must be an active member of the RAC for the TSA of their contracted service area and meet that RAC's definition of participation and requirements listed in subparagraph (E)(i)-(vi) of this paragraph; and

(iv) it is the responsibility of an EMS provider to contact each RAC in which it operates to ensure knowledge of the provider's presence and potential eligibility for funding from the EMS allotment related to that RAC's TSA;

(E) if an EMS provider is serving any county beyond its county of licensure it must provide to the department evidence of a contract or letter of agreement with each additional county government or taxing authority in which service is provided:

(i) inter-facility transfer letters of agreement and/or contracts, as well as mutual aid letters of agreement and/or contracts, do not meet this requirement;

(ii) contracts or letters of agreement must be dated and submitted to the department on or before August 31 of the respective year, and be effective more than six months of the upcoming fiscal year;

(iii) effective dates of the contracts or letters of agreement should be provided;

(iv) EMS providers with contracts or letters of agreement on file with the department which include contract service dates that meet the required time period (noted in this subsection) need not resubmit;

(v) EMS providers are responsible for assuring that all necessary portions of their contracts and letters of agreement have been received by the department; and

(vi) air ambulance providers must meet the same requirements as

ground transport EMS providers to be eligible to receive funds from a specific county other than the county of licensure; and

(F) if a EMS provider is licensed in a particular county and has a contract (with a county government or taxing authority) for a service area which is a geopolitical subdivision (examples listed below) whose boundary lines cross multiple county lines, it will be considered eligible for the 911 EMS Allocation for all counties overlapped by that geopolitical subdivision's boundary lines. A contract with every county that composes the geopolitical subdivision is not necessary. And, the eligibility of EMS providers, whose county of licensure is in a geopolitical subdivision other than those listed in clauses (i) – (vi) of this subparagraph, will be evaluated on a case-by-case basis.

- (i) Municipalities.
- (ii) School districts.
- (iii) Emergency service districts (ESDs).
- (iv) Hospital districts.
- (v) Utility districts.
- (vi) Prison districts.

(3) RAC Allocation. To be eligible for funding from the TSA allocation, a RAC must:

(A) be officially recognized by the department as described in §157.123 of this title (relating to Regional Emergency Medical Services/Trauma Systems);

(B) be incorporated as an entity that is exempt from federal income tax under §501(a) of the United States Internal Revenue Code of 1986, and its subsequent amendments, by being listed as an exempt organization under §501(c)(3) of the code;

(C) submit documentation of ongoing system development activity and future planning;

(D) have demonstrated that a regional system performance improvement process is ongoing by submitting to the department the following:

(i) lists of committee meeting dates and attendance rosters for the RAC'S most recent fiscal year;

(ii) committee membership rosters which included each member's organization or constituency; or

(iii) lists of issues being reviewed in the system performance improvement meetings.

(E) Submit all required EMS allocation eligibility items addressed in paragraph (2)(B)-(C) of this subsection.

(4) To be eligible to distribute the EMS and TSA allocations, a RAC must be incorporated as an entity that is exempt from federal income tax under §501(a) of the Internal Revenue Code of 1986, and its subsequent amendments, by being listed as an exempt organization under §501(c)(3) of the code.

(5) Hospital Allocation. To be eligible for funding from the hospital allocation, a hospital must be a department designated trauma facility or in active pursuit of a department designation as a trauma facility or a Department of Defense hospital that is a department designated trauma facility or in active pursuit of a department designation as a trauma facility.

(A) To receive funding from the hospital allocation, an application must be submitted within the time frame specified by the department and include the following:

- (i) name of facility;
- (ii) location of facility including mailing address, city and county;
- (iii) Texas Provider Identifier (TPI number) or accepted federal identification number.

(B) The application must be signed and sworn to before a Texas Notary Public by the chief financial officer, chief executive officer and the chairman of the facility's board of directors.

(C) A copy of the application shall be distributed by Level I, II, or III facilities to the trauma medical director and Level IV facilities to the physician director.

(D) Additional information may be requested at the department's discretion.

(E) A TDH-designated trauma facility in receipt of funding from the hospital allocation that fails to maintain designation through December 31, 2005, must return an amount as follows to the account by no later than January 31, 2006:

(i) 1 to 60 days lapsed designation: 0% of the facility's hospital allocation for FY04 and FY05;

(ii) 60 to 180 days lapsed designation: 25% of the facility's hospital allocation for FY04 and FY05 plus a penalty of 10%;

(iii) greater than 180 days lapsed designation: 100% of the facility's hospital allocation for FY04 and FY05 plus a penalty of 10%; and

(iv) the department may grant an exception to subparagraph (E) of this

subsection if it finds that compliance with this section would not be in the best interests of the persons served in the affected local system.

(F) A facility in active pursuit of designation but has not achieved TDH-trauma designation by December 31, 2005, must return to the account by no later than January 31, 2006, all funds received from the hospital allocation in FY04 and FY05 plus a penalty of 10%.

(e) Calculation Methods. Calculation of county shares of the EMS allocation, the RAC shares of the TSA allocation, and the hospital allocation.

(1) EMS allocation.

(A) Counties will be classified as urban or rural based on the latest official federal census population figures.

(B) The EMS allocation will be derived by adjusting the weight of the statutory criteria in such a fashion that, in so far as possible, 40% of the funds are allocated to urban counties and 60% are allocated to rural counties.

(C) An individual county's share of the EMS allocation shall be based on its geographic size, population, and number of emergency health care runs multiplied by adjustment factors, determined by the department, so the distribution approximates the required percentages to urban and rural counties.

(D) The formula shall be:
$$\frac{[(\text{the county's population multiplied by an adjustment factor}) + (\text{the county's geographic size multiplied by an adjustment factor}) + (\text{the county's total emergency health care runs multiplied by an adjustment factor})]}{3}$$
 multiplied by (the total EMS allocation). The adjustment factors will be manipulated so that the distribution approximates the required percentages to urban and rural counties. Total emergency health care runs shall be the number of emergency runs electronically transmitted to the department in a given calendar year by EMS providers.

(2) TSA allocation.

(A) A RAC's share of the TSA allocation shall be based on its relative geographic size, population, and trauma care provided as compared to all other TSAs.

(B) The formula shall be:
$$\frac{[(\text{the TSA's percentage of the state's total population}) + (\text{the TSA's percentage of the state's total geographic size}) + (\text{the TSA's percentage of the state's total trauma care})]}{3}$$
 multiplied by (the total TSA allocation). Total trauma care shall be the number of trauma patient records electronically transmitted to the department in a given calendar year by EMS providers and hospitals.

(3) Hospital allocation.

(A) There will be one annual application process from which all distributions

from the hospital allocation, plus any unexpended portion of the EMS and TSA allocations, in a given fiscal year will be made. The department will notify all eligible designated trauma facilities and those hospitals in active pursuit of designation at least 90 days prior to the due date of the annual application. Based on the information provided in the application, each facility shall receive:

(i) an equal amount, with an upper limit of \$50,000, from up to 15 percent of the hospital allocation; and

(ii) an amount for uncompensated trauma care as determined in subparagraphs (B)-(C) of this paragraph, less the amount received in clause (i) of this subparagraph.

(B) Any funds not allocated in subparagraph (A)(i) of this paragraph shall be included in the distribution formula in subparagraph (D) of this paragraph.

(C) If the total cost of uncompensated trauma care exceeds the amount appropriated from the account, minus the amount referred to in subparagraph (A)(i) of this paragraph, the department shall allocate funds based on a facility's percentage of uncompensated trauma care costs in relation to the total uncompensated trauma care cost reported by qualified hospitals that year.

(D) In the first year of distribution, the hospital allocation formula for Level I, II, III and IV trauma facilities and those facilities in active pursuit of designation shall be:
$$\frac{[(\text{the facility's reported costs of uncompensated trauma care}) \div (\text{the total reported cost of uncompensated trauma care by qualified hospitals that year})]}{1}$$
 multiplied by (total money available for facilities minus the amount referred to in subparagraph (A)(i) of this paragraph).

(E) In subsequent years of distribution, the hospital allocation formula for Level I, II, III and IV trauma facilities and those facilities in active pursuit of designation shall be:
$$\frac{[(\text{the facility's reported costs of uncompensated trauma care}) \text{ minus } (\text{any collections received by the hospitals for any portion of their uncompensated care previously reported for the purposes of this section}) \div (\text{the total reported cost of uncompensated trauma care by qualified hospitals that year})]}{1}$$
 multiplied by (total money available for facilities minus the amount distributed in subparagraph (A)(i) of this paragraph).

(F) For purposes of subparagraphs (D) - (E) of this paragraph, the reporting period of a facility's uncompensated trauma care shall apply to costs incurred during the preceding calendar year.

(G) Hospitals should have a physician incentive plan that supports the facility's participation in the trauma system.

(f) Loss of funding eligibility. If the department finds that an EMS provider, RAC, or hospital has violated the Health and Safety Code, §780.004, or fails to comply with this section, the department may withhold account monies for a period of one to three years depending upon the seriousness of the infraction.