Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353. MEDICAID MANAGED CARE SUBCHAPTER O. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

1 TAC §353.1301

The Texas Health and Human Service Commission (HHSC) adopts new Subchapter O, concerning Delivery System and Provider Payment Initiatives, and new §353.1301, concerning General Provisions. The new rule is adopted with changes to the proposed text as published in the January 20, 2017, issue of the *Texas Register* (42 TexReg 169). The text of the rule will be republished.

BACKGROUND AND JUSTIFICATION

This new rule describes certain general provisions that will apply to all Medicaid managed care delivery system and provider payment initiatives, or directed payments. As part of the recent overhaul of federal Medicaid managed care (MMC) rules, the Centers for Medicare & Medicaid Services (CMS) allowed states that operate MMC to direct managed care organizations' (MCOs') payments to providers. This rule describes provisions HHSC considers to be universal to all such directed payment programs that are, or will be, implemented in Texas. The Quality Incentive Payment Program for Nursing Facilities (QIPP) and the Uniform Hospital Rate Increase Program (UHRIP) are being implemented under this subchapter through new §353.1303 and §353.1305, respectively, which are being adopted concurrently.

COMMENTS

The 30-day comment period ended February 21, 2017. During this period, HHSC received comments regarding the new rule from twenty-five (25) entities, including:

Adelanto HealthCare Ventures

Baylor Scott & White Health

Bexar County Hospital District dba University Health System

Children's Health of Dallas

Cook Children's Hospital

CRISTUS Health

Driscoll Children's Hospital

Ector County Hospital District

Falls Community Hospital and Clinic (FCHC)

Hospital Corporation of America (HCA)

Memorial Hermann Health System

Midland Memorial Hospital

Nueces County Hospital District (NCHD)

Parkland Health & Hospital System

Teaching Hospitals of Texas (THOT)

Tenet Healthcare

Texas Association of Health Plans (TAHP)

Texas Children's Hospital

Texas Health Resources

Texas Hospital Association (THA)

Texas Organization of Rural and Community Hospitals (TORCH)

Texas Rural Health Association

University Medical Center Health System (UMC Lubbock)

University Medical Center of El Paso (UMC El Paso)

University of Texas Physicians (UT Physicians)

A summary of comments and HHSC's responses follow.

Definitions

Comment: Two commenters requested that HHSC clarify the definition of "public funds" in subsection (b)(10) to ensure that the clause "within the sole and unrestricted control of a governmental entity" applies only to "other public revenues," and not to taxes, assessments, levies, and investments. The commenters noted that other law, like the statutes authorizing Local Provider Participation Funds (LPPFs), may restrict the uses of funds derived from those sources.

Response: The definition of "public funds" that was proposed in this rule is identical to the definition of the term in other administrative rules and, to HHSC's knowledge, has not resulted in confusion regarding the permissible sources of public funds that may be transferred to HHSC to support supplemental payments. However, in light of the increased use of LPPFs in the state, and to avoid any concerns about the use of such funds for the purposes described in this subchapter, HHSC amended subsection (b)(10) in response to this comment.

Source of the non-federal share

Comment: As proposed, subsection (e)(2) limits the source of the non-federal share of payments to non-state-owned providers to IGTs from non-state governmental entities. One commenter noted that in other hospital supplemental payment programs, state general revenue appropriated to other state agencies is transferred to HHSC as the non-federal share of payments to

non-state providers. The commenter requested that HHSC amend proposed subsection (e)(2) to allow that practice in the programs described in this subchapter.

Response: HHSC agrees with this comment. The intent of the language as proposed in (e)(2) was to exclude state general revenue appropriated to HHSC as a source of the non-federal share available for non-state providers. HHSC did not intend to preclude the use of funds appropriated to other state agencies or state-owned providers that might wish to transfer funds to HHSC for the purposes described in this subchapter. The rule was changed in response to this comment.

Reconciliation of the non-federal share

Comment: One commenter suggested HHSC establish a process to ensure that the encounter data submitted by MCOs is correct and that payment reconciliations are done expeditiously.

Response: HHSC declines to revise the subsection, but agrees with the commenter on the importance of accurate encounter data. HHSC always works to ensure that the encounter data reported by MCOs is accurate.

Failure of a governmental entity to transfer funds

Comment: Some commenters asked HHSC to delete the penalties in subsection (h) for governmental entities that fail to transfer funds timely. One commenter specifically requested that HHSC remove the language making providers operated by such a governmental entity ineligible for future participation in programs under this subchapter.

Response: Subsection (h) is intended to protect state general revenue by describing the method the state will use to recover its expenditures: withholding Medicaid payments from a provider operated by the governmental entity that does not timely complete the transfer of funds. It is appropriate to retain that language in the rule so that all participants are aware of the consequences of failure to timely transfer. However, HHSC agrees that ineligibility for future participation in Subchapter O programs may unnecessarily penalize some public providers. In response to this comment, HHSC revised subsection (h) to delete the sentence related to future program ineligibility.

Comment: Two commenters asked HHSC to delete subsection (h) because the provision "conditions participation on IGT agreements."

Response: HHSC disagrees with this statement. Subsection (h) does not require IGT commitment agreements. It is unlikely this provision will ever be invoked, since funds to support payments under this subchapter are transferred to HHSC in advance of the state expending the funds. However, in the unlikely event that state general revenue has been expended as a result of the failure of a governmental entity to transfer funds, it is appropriate for the administrative rule to describe the method that the state will employ to recover the state's expenditure. No changes were made to the rule in response to this comment.

Comment: One commenter suggested that HHSC revise subsection (h) to withhold payments from all providers receiving enhanced payments under this subchapter, not just those operated by the governmental entity.

Response: Subsection (h) as proposed describes the method HHSC will use to recover its expenditures when a governmental entity has failed to timely transfer funds for the purposes described in the subchapter. The funds that replenish the state's expenditures in these programs must be public funds. Medicaid payments to publicly operated providers are public funds; Medicaid payments to privately operated providers are not. Withholding Medicaid payments from privately operated providers to recover the state's expenditures would result in an impermissible provider donation from the private provider to the state. Consequently, the commenter's suggestion is not acceptable. No changes were made to the rule in response to this comment.

Comment: One commenter encouraged HHSC to add language to subsection (h) providing for a "cure period" to allow a governmental entity an opportunity to remedy a funding shortfall before withholding provider payments from providers operated by that entity.

Response: HHSC cannot agree to this request because it creates uncertainty in the timing of the state's recovery of its expenditures. HHSC is unwilling to float the funds while the governmental entity attempts to cure the shortfall. For that reason, the state will initiate the process of placing the public provider on payment hold as soon as possible after the transfer deadline is missed. Of course, the state will stop the process or lift the payment hold as soon as the governmental entity transfers the funds to HHSC or otherwise cures the shortfall. No changes were made to the rule in response to this comment.

Failure of an MCO to comply with contract provisions

Comment: One commenter noted that subsection (i) uses the permissive phrase "may investigate" to describe HHSC's response to provider claims of contract violations by the MCOs. The commenter requested that HHSC revise subsection (i) to eliminate uncertainty and to establish that HHSC will investigate provider claims of contract violations by MCOs.

Response: HHSC agrees with this comment. HHSC changed subsection (i) to clarify that HHSC will investigate all provider claims of contract violations related to directed expenditures under this subchapter.

Disallowance of federal funds

Comment: Several commenters suggested that HHSC delete subsection (j)(1) which provides that, in the event of a disallowance by CMS on the basis of an impermissible provider donation, the governmental entity responsible for the non-federal share must transfer funds to HHSC in the amount of the disallowance. Some commenters said this provision would place an undue burden on governmental entities responsible for the non-federal share by requiring that such entities be solely responsible for repayments; other commenters simply suggested that subsection (j)(2) could cover every possible type of disallowance and give HHSC the flexibility to recoup from all program participants, i.e., MCOs, providers, and/or sponsoring governmental entities. One commenter suggested excepting public rural and community hospitals from this provision. Another commenter stated that providers should be responsible in the event of a disallowance because they received the funds.

Response: HHSC disagrees and declines to revise the subsection as the commenters suggest. HHSC believes this provision is necessary in light of recent heightened scrutiny by CMS of the funding arrangements underlying payments to private providers and because of the uncertain authority of HHSC to recoup from providers or the MCO when CMS disallows federal funds on these grounds. The safest option in this scenario is to obtain funds from the governmental entities (including public rural and community hospitals) to cover the non-federal share of disallowed payments. HHSC does not think the same is true when

CMS disallows federal funds on grounds other than provider donations. In such cases, relying on other federal and state law and contract authority to recoup from MCOs, providers, or governmental entities is appropriate.

Comment: One commenter suggested amending subsection (j)(2) to give an MCO the express ability to recoup from the provider. The commenter noted that subsection (k)(2) contains such a statement, but requested that it be in subsection (j)(2) as well.

Response: The commenter is correct that subsection (k)(2) gives MCOs the authority to recoup overpayments from providers. HHSC does not believe that this provision should also be in subsection (j)(2).

Recoupment

Comment: Two commenters suggested that HHSC revise subsection (k)(1) so that recoupments of overpayments from MCOs are returned to the governmental entity that provided the funds.

Response: HHSC disagrees and declines to revise the subsection as the commenters suggest. The reconciliation process described in subsection (g) takes into account recoupments of overpayments from MCOs. Following reconciliation, to the extent that funds are not needed to cover expenditures, they may be returned to the governmental entity.

Comment: One commenter expressed concern about subsection (k)(3), which authorizes MCOs to recoup from a provider when payments to that provider were made in error or due to fraud. The commenter stated that providers have no recourse against an MCO if the provider disagrees with the recoupment action.

Response: The rule, as proposed, does not modify any statutory or contractual rights a provider has to dispute an action taken by an MCO with which the provider disagrees. Texas Government Code §§533.005(15) and (19) require that MCO contracts include provisions for tracking and resolving provider complaints regarding claims and for responding to provider appeals. Those requirements are also included in the HHSC-MCO Uniform Managed Care Contract at 8.2.4. MCOs that fail to resolve provider complaints as required in the statute and Uniform Managed Care Contract are subject to liquidated damages or other appropriate penalties. No changes were made to the rule in response to this comment.

State's cost of administering programs

Comment: Two commenters suggested that HHSC revise subsection (l) because it is unclear what may qualify as "the state's cost of administering a program" and what it means to be "generating the costs." As a result, said the commenters, it will be difficult for program participants to estimate the state's costs and predict any potential financial responsibility related to such costs.

Response: HHSC declines to revise the subsection, but it intends to provide adequate advance notice before collecting the state's costs to administer a program under new Subchapter O, Delivery System and Provider Payment Initiatives. Additionally, HHSC anticipates that the costs associated with UHRIP and QIPP will be minimal and far outweighed by the benefits of participation in these programs.

Comment: Two commenters stated that HHSC does not quantify or project the amount of costs for which the participating hospitals in UHRIP will be responsible, and the hospitals need this information to forecast the overall funding requirements for a SDA. They also observed that the administrative cost of the program will depend on how HHSC ultimately structures it.

Response: HHSC agrees with the commenters that administrative costs of programs under new Subchapter O will depend on how HHSC ultimately structures them, but HHSC cannot quantify or project the costs of these programs in the rule at this time.

Comment: One commenter suggested that HHSC clarify which program participants are responsible for the state's administrative costs. The commenter, who was addressing this requirement in the context of UHRIP, observed that this requirement appears to include any entity receiving a rate increase.

Response: HHSC confirms the commenter's understanding that this subsection can apply to entities receiving a rate increase through UHRIP. However, subsection (l) applies to all programs under Subchapter O, and these programs may have different participants. For this reason, HHSC declines to revise the subsection as the commenter suggests. In regards to UHRIP, HHSC would also say that it is appropriate that entities receiving a rate increase through the program should be responsible for the state's costs of administering the program.

Changes from the proposed version that are not in response to comments

The following change to the final rule from the proposed version was made by HHSC to improve the clarity of the rule, and not in response to a comment:

Subsection (k), relating to recoupment, was revised to clarify that nothing in the rule may be construed to limit the independent authority of another federal or state agency to recover from a provider for a payment made due to fraud.

STATUTORY AUTHORITY

The new rule is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code, Chapter 32; and with Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

§353.1301. General Provisions.

(a) Purpose. The purpose of this subchapter is to describe the circumstances and programs under which the Texas Health and Human Services Commission may direct expenditures for delivery system and provider payment initiatives through its contracts with Medicaid managed care organizations. Federal authority for such directed expenditures is codified at 42 C.F.R. §438.6(c).

(b) Definitions. The following definitions apply when the terms are used in this subchapter. Terms that are used in only one program described in this subchapter may be defined in the section of this subchapter describing that program.

(1) Capitation rate--A fixed, predetermined fee paid by HHSC to the managed care organization each month, in accordance with the contract, for each enrolled member. In exchange for this, the managed care organization arranges for or provides a defined set of covered services to the enrolled member, regardless of the amount of covered services used by the enrolled member.

(2) Centers for Medicare & Medicaid Services (CMS)--The federal agency within the United States Department of Health and Human Services responsible for overseeing and directing Medicare and Medicaid.

(3) HHSC--The Texas Health and Human Services Commission or its designee.

(4) Intergovernmental transfer (IGT)--A transfer of public funds from another state agency or a non-state governmental entity to HHSC.

(5) Managed care organization (MCO)--A Medicaid managed care organization contracted with HHSC to provide health care services to Medicaid recipients.

(6) Non-federal share--The portion of program expenditures that is not federal funds. The non-federal share is equal to 100 percent minus the federal medical assistance percentage (FMAP) for Texas for the state fiscal year corresponding to the program year and for the population served.

(7) Non-state governmental entity--A hospital authority, hospital district, health district, city, or county.

(8) Program rate component--The fixed percentage of the capitation rate that is attributable to the delivery system or provider payment initiative.

(9) Provider--A credentialed and licensed individual, facility, agency, institution, organization, or other entity that has a contract with the MCO for the delivery of covered services to the MCO's members.

(10) Public funds--Funds derived from taxes, assessments, levies, and investments. Public funds also include other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(11) Service delivery area--The counties included in any HHSC-defined geographic area as applicable to each MCO.

(12) Sponsoring governmental entity--A state or non-state governmental entity that agrees to transfer to HHSC some or all of the non-federal share of program expenditures under this subchapter.

(c) CMS approval. Implementation of each of the programs described in this subchapter is contingent upon HHSC receiving written approval from CMS of the contract provisions directing the MCO expenditures. Federal requirements for CMS approval of directed MCO expenditures are codified in 42 C.F.R. §438.6(c)(2).

(d) Program specifications, provider eligibility, and payment calculations. Descriptions of program specifications, provider eligibility, and payment calculations are contained in the sections of this subchapter that describe each delivery system or provider payment initiative program.

(e) Source of the non-federal share. The non-federal share of expenditures under this subchapter is limited to timely receipt by HHSC of public funds from sponsoring governmental entities.

(1) State-owned providers. A state-owned provider may transfer to HHSC any non-federal funds within the control of the provider, including appropriated state general revenue funds, as the non-federal share of program expenditures associated with that provider.

(2) All other providers. For all other providers, the non-federal share of program expenditures is funded through IGTs. No state general revenue appropriated to HHSC is available to support program expenditures to non-state providers under this subchapter.

(f) Amount and timing of transfer of the non-federal share. The amount of the non-federal share that governmental entities transfer to HHSC for expenditures under this subchapter and the timing of such transfers are specific to each delivery system or provider payment initiative and are described in the section of this subchapter governing each such program.

(g) Reconciliation of the non-federal share.

(1) Purpose. The amount of HHSC's expenditures under this subchapter is dependent on member enrollment in each participating MCO, which may fluctuate from month to month. HHSC's actual expenditures cannot be determined until final member enrollment data is available, which may not occur for up to two years following the end of the program period. The purpose of the reconciliation process is to ensure that HHSC's actual total expenditures for each program are determined based on accurate and final member enrollment data for each program period, and that the non-federal share of HHSC's actual expenditures are borne by the appropriate governmental entity or entities.

(2) Methodology. For each program described in this subchapter, HHSC reconciles the amount of the non-federal funds actually expended during the program period with the amount of funds transferred to HHSC by the sponsoring governmental entities. For programs with multiple provider classes, HHSC reconciles expenditures for each provider class. HHSC completes each reconciliation in multiple parts.

(A) The first reconciliation occurs no later than 120 days after the end of the program period.

(i) Using the best-available member enrollment data at the time of the first reconciliation, HHSC:

(I) calculates the amount expended for the program period by multiplying the program rate component by the total member months included in the program period;

(II) calculates the non-federal share of the amount determined in subclause (I) of this clause; and

(III) compares the amount determined in subclause (II) of this clause to the amount previously transferred to HHSC by the participating governmental entities for the program period.

(ii) If the amount previously transferred is less than 102 percent of the amount determined in clause (i)(II) of this subparagraph:

(I) the participating governmental entities must transfer additional funds to HHSC such that total transferred funds equals 102 percent of the amount determined in clause (i)(II) of this subparagraph;

(II) if more than one governmental entity is responsible for the non-federal share of payments under the program, the additional required funds are allocated proportional to each governmental entity's initial contribution to funding the program; and

(III) HHSC notifies the governmental entities of the amount and timing of the required transfers.

(iii) If the amount previously transferred is more than 102 percent of the amount determined in clause (i)(II) of this subparagraph, HHSC refunds the excess amount to the governmental entities in proportion to each entity's initial contribution to funding the program.

(B) Interim reconciliations may occur as updated member enrollment data for the program period becomes available. HHSC

follows the process described in subparagraph (A) of this paragraph for such interim reconciliations.

(C) The final reconciliation occurs no later than 25 months after the end of the program period.

(i) Using the final member enrollment data for the program period, HHSC:

(I) calculates the amount expended for the program period by multiplying the program rate component by the total member months included in the program period;

(II) calculates the non-federal share of the amount determined in subclause (I) of this clause; and

(III) compares the amount determined in subclause (II) of this clause to the amount previously transferred to HHSC by the sponsoring governmental entities for the program period, including any amounts transferred pursuant to subparagraphs (A)(ii) or (B) of this paragraph.

(ii) If the amount previously transferred is less than the non-federal share of the amount expended:

(I) the participating governmental entities must transfer additional funds to HHSC such that total transferred funds equals the amount determined in clause (i)(II) of this subparagraph;

(II) if more than one governmental entity is responsible for the non-federal share of payments under the program, the additional required funds are allocated proportional to each governmental entity's initial contribution to funding the program; and

(III) HHSC notifies the governmental entities of the amount and timing of the required transfers.

(iii) If the amount previously transferred is more than the amount determined in clause (i)(II) of this subparagraph, HHSC refunds the excess amount to the governmental entities in proportion to each entity's initial contribution to funding the program.

(h) Failure of a governmental entity to transfer funds. If a governmental entity does not timely complete the transfer of funds described in this section, HHSC withholds Medicaid payments from any provider operated by the governmental entity until HHSC has recovered an amount equal to the amount of the funding shortfall.

(i) Failure of an MCO to comply with contract provisions. HHSC may review MCO payments to network providers or other documentation to verify that the MCO is in compliance with contract provisions directing expenditures for delivery system and provider payment initiatives. HHSC must investigate provider claims of contract violations. In the event HHSC identifies any contract deficiency or violation, HHSC takes corrective action to remedy such deficiency or violation, as authorized by §353.5 of this chapter (relating to Internet Posting of Sanctions Imposed For Contractual Violations).

(j) Disallowance of federal funds.

(1) If an arrangement associated with the funding of payments under this subchapter is determined by CMS to constitute an impermissible provider donation, resulting in a disallowance of federal matching funds, the governmental entities responsible for the non-federal share of such payments must transfer funds to HHSC in the amount of the disallowed federal funds. HHSC notifies the governmental entities of the amount and timing of the required transfers.

(2) If payments under this subchapter are disallowed by CMS on grounds other than those described in paragraph (1) of this subsection, to the extent allowed by federal and state law and contract, HHSC may recoup the amount of the disallowance from MCOs, providers, or governmental entities that participated in the program associated with the disallowance.

(k) Recoupment.

(1) If payments under this subchapter result in an overpayment to an MCO, HHSC may recoup the amount of the overpayment from the MCO, pursuant to the terms of the contract between them.

(2) If payments under this subchapter result in an overpayment to a provider, the MCO may recoup an amount equivalent to the overpayment.

(3) Payments made under this subchapter may be subject to any adjustments for payments made in error or due to fraud, including without limitation adjustments made under the Texas Administrative Code, the Code of Federal Regulations, and state and federal statutes. The MCOs may recoup an amount equal to any such adjustments from the providers in question. Nothing in this section may be construed to limit the independent authority of another federal or state agency or organization to recover from the provider for a payment made due to fraud.

(l) State's cost of administering programs. To the extent authorized under state and federal law, HHSC will collect the state's cost of administering a program authorized under this subchapter from participants in the program generating the costs.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on March 20, 2017.

TRD-201701183
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: April 9, 2017
Proposal publication date: January 20, 2017
For further information, please call: (512) 707-6079

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~~**1 TAC §353.1303**~~

~~The Texas Health and Human Services Commission (HHSC) adopts new §353.1303, concerning Quality Incentive Payment Program for Nursing Facilities, with changes to the proposed text as published in the January 20, 2017, issue of the *Texas Register* (42 TexReg 172). Therefore, the text of the rule will be republished.~~

~~Background and Justification~~

~~This new rule describes the Quality Incentive Payment Program (QIPP). QIPP is designed to incentivize nursing facilities (NFs) to improve quality and innovation in the provision of NF services, using the Centers for Medicare & Medicaid (CMS) Five-Star Quality Rating System as the measure of success.~~

~~During the 83rd Session, the Texas Legislature outlined its goals for the Medicaid managed care carve-in of NFs. In implementing the NF carve-in, HHSC was directed to encourage transformative efforts in the delivery of NF services, including "efforts to promote a resident centered care culture through facility design and services provided" (Senate Bill 7, 83rd Texas Legislature, Regular Session, 2013).~~

ment-owned eligibility requirements described in this section in order to continue QIPP participation during the eligibility period.

(k) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(k) of this subchapter.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on March 20, 2017.

TRD-201701184
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: April 9, 2017
Proposal publication date: January 20, 2017
For further information, please call: (512) 707-6079

♦ ♦ ♦

1 TAC §353.1305

The Texas Health and Human Service Commission (HHSC) adopts new Subchapter O, concerning Delivery System and Provider Payment Initiatives, and new §353.1305, concerning Uniform Hospital Rate Increase Program. The new rule is adopted with changes to the proposed text published in the January 20, 2017, issue of the *Texas Register* (42 TexReg 177). The text of the rule will be republished.

BACKGROUND AND JUSTIFICATION

This new rule describes the circumstances under which HHSC will direct a Medicaid managed care organization (MCO) to provide a uniform percentage rate increase to hospitals in the MCO's network in a participating service delivery area (SDA) for the provision of inpatient services, outpatient services, or both. The rule also describes the methodology used by HHSC to determine the percentage rate increase.

Currently, Texas' Medicaid hospital payments, made through either the fee-for-service (FFS) or managed care models, do not fully cover Medicaid allowable costs for hospital services. A portion of the Medicaid shortfall is reimbursed through supplemental payment programs such as the disproportionate share hospital (DSH) program and the uncompensated care (UC) pool under the 1115 waiver known as the Texas Healthcare Transformation and Quality Improvement Program. These supplemental payments are paid outside of the managed care capitation apparatus and, for payments to non-state-owned providers, rely on intergovernmental transfers (IGTs) from non-state governmental entities or other state agencies for the non-federal share of the payments.

Healthcare policy experts posit that reimbursing provider costs more fully through managed care payments would enhance care coordination. Flowing additional funds for hospital services prospectively through managed care entities, rather than retrospectively reimbursing hospitals for services provided but not fully reimbursed through Medicaid, would increase the ability of the state and its managed care contractors to pursue approaches to provider reimbursement that prioritize achieving health outcomes versus the delivery of services.

In May 2016, the Centers for Medicare & Medicaid Services (CMS) finalized a rule (42 C.F.R. §438.6(c)) that allows a state to direct expenditures under its contracts with MCOs under certain limited circumstances. Under the new federal rule, a state may direct an MCO to raise rates for a class of providers of a particular service by a uniform dollar amount or percentage, subject to approval of the contract arrangements by CMS. To obtain approval, the arrangements must be based on the utilization and delivery of services; direct expenditures equally for a class of providers of a particular service; advance at least one of the goals and objectives of the state's quality strategy and have an evaluation plan to measure the effectiveness of the arrangements at doing so; not condition provider participation on an IGT; and not be automatically renewed.

In light of the recent federal regulation and with the goal of enhancing care coordination and achieving better health outcomes, this rule authorizes HHSC to use IGTs from non-state governmental entities or from other state agencies to support capitation payment increases in one or more SDAs. Each MCO within the SDA would then be contractually required by the state to increase hospital payment rates by a uniform percentage for one or more classes of hospital that provide services within the SDA.

HHSC has been asked if it intends to review the contracts between MCOs and hospitals; it does not. Neither the rule nor the contract language directing the rate increase are intended to modify other managed-care payment rules or impact other provisions of the contracts between the MCO and its network hospitals.

Participation in the Uniform Hospital Rate Increase Program (UHRIP) is voluntary, and sponsoring governmental entities propose the amount of IGT to transfer to HHSC to support the non-federal share of the increased rates.

This new rule is under new Subchapter O, concerning Delivery System and Provider Payment Initiatives, and is being adopted concurrently with new §353.1301, concerning General Provisions, and new §353.1303, concerning Quality Incentive Payment Program for Nursing Facilities (QIPP). Section 353.1301 describes provisions HHSC considers to be universal to the UHRIP, QIPP, and other directed payment programs that may be implemented in Texas in the future.

COMMENTS

The 30-day comment period ended February 21, 2017. During this period, HHSC received written comments regarding the new rule from thirty-two (32) entities including:

Adelanto HealthCare Ventures

Baylor Scott & White Health

Bexar County Hospital District dba University Health System

Children's Health of Dallas

Children's Hospital Association (CHAT)

Cook Children's Hospital

Covenant Health

CRISTUS Health

Driscoll Children's Hospital

Driscoll Health Plan

Ector County Hospital District

Electra Hospital District

Falls Community Hospital and Clinic (FCHC)

Hospital Corporation of America (HCA)

Memorial Hermann Health System

Midland Memorial Hospital

Nueces County Hospital District (NCHD)

Odessa Regional Medical Center

Parkland Health & Hospital System

Stonewall Memorial Hospital District

Superior HealthPlan

Teaching Hospitals of Texas (THOT)

Tenet Healthcare

Texas Association of Community Health Plans (TACHP)

Texas Children's Hospital

Texas Health Resources

Texas Hospital Association (THA)

Texas Organization of Rural and Community Hospitals (TORCH)

Texas Rural Health Association

University Medical Center Health System (UMC Lubbock)

University Medical Center of El Paso (UMC El Paso)

University of Texas Physicians (UT Physicians)

A summary of comments and HHSC's responses follow.

Definitions

Comment: Some commenters suggested revising the definitions of the terms "children's hospital" and "outpatient services" to provide flexibility for rate increases to physicians and other providers affiliated with children's hospitals. According to the commenters, providing for rate increases for these providers would ensure that primary and specialty care services are available to Medicaid enrollees and would prioritize achieving health outcomes, which is consistent with the stated goals of this program.

Response: The revision suggested by the commenters would affect persons (physicians and other providers) who were not put on notice that the proposed rule would impact their Medicaid reimbursement. The entities that would be impacted by the proposed rule (hospitals, MCOs, and sponsoring governmental entities) were not put on notice that non-hospital providers might receive a rate increase through the program. These persons and entities would be deprived of the opportunity for meaningful input on the rule. To ensure adequate notice to all persons that would be impacted by the rule, HHSC would be required to republish the modified rule. HHSC is unwilling to re-publish the modified proposed rule because the delay caused by re-publication would make implementation of hospital rate increases on September 1, 2017, impossible.

It is also significant that the commenters' proposal is inconsistent with the description of this program provided to CMS. CMS approval of the program is a prerequisite to implementation and making this modification would set back the progress that the state has made so far in obtaining that approval.

HHSC encourages stakeholders to submit proposals for additional delivery system and provider payment initiatives under Subchapter O that may provide for enhanced rates to providers other than hospitals. However, for the reasons explained in this response, this rule action is not the appropriate vehicle for that purpose. No changes were made to the rule in response to this comment.

Comment: Multiple commenters noted that publicly-operated hospitals located in counties of fewer than 60,000 persons meet the definition of both a "non-urban public hospital," as defined in subsection (b)(4)(A) of the proposed rule, and a "rural hospital," as defined in subsection (b)(7) of the proposed rule. The commenters asked for clarity in the definitions.

Response: HHSC agrees that the proposed definitions would have allowed a hospital to fall into two classes, which was not HHSC's intent. HHSC changed the definition of "non-urban public hospital" in subsection (b)(4)(A) to exclude rural public hospitals and added a definition of "rural public hospital" in subsection (b)(8). Subsection (c)(1) was also revised to identify two separate classes of participating rural hospital: private and public.

Comment: Commenters suggested that the definition of "rural hospital" in proposed subsection (b)(7) is appropriate to determine which hospitals are classified as "rural," rather than the definition of "non-urban public hospital" in proposed (b)(4)(A). However, the commenters asked HHSC to create separate classes for "rural private" and "rural public" hospitals.

Response: HHSC agrees with this comment. There may be operational differences between publicly-operated and privately-operated rural hospitals that warrant different percentage rate increases between the two classes. Subsection (b)(7) was revised to define a "rural private hospital" as a "privately-operated hospital located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated rural referral center, a sole community hospital, or a critical access hospital." Subsection (b)(8) was added to define a "rural public hospital" as a " hospital that is owned and operated by a governmental entity and is located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated rural referral center, a sole community hospital, or a critical access hospital." Subsection (c)(1) was also revised to identify two separate classes of participating rural hospital: private and public.

Classes of participating hospitals

Comment: One commenter pointed out the possibility that a class of hospital might have only one hospital and requested confirmation that such a class would be allowable for payment distribution.

Response: HHSC agrees with the commenter that it is possible to have a one-hospital class in some SDAs. To promote consistency of treatment across several reimbursement programs, HHSC proposed classifying hospitals using definitions drawn from other programs such as the Disproportionate Share Hospital (DSH) program and the section 1115 waiver Uncompensated Care (UC) program. The result is that some classes may have only one or two hospitals within any given SDA. There is nothing in the rule or policy that would prohibit that hospital from a rate increase. However, it is unlikely that HHSC or CMS would approve a proposal for a rate increase to benefit only a single-hospital class within the SDA. HHSC expects SDAs to submit applications providing for rate increases to most if not all of the classes within the SDA, unless there is an explanation for excluding a class from the program in that SDA. No changes were made to the rule in response to this comment.

Comment: One commenter requested that HHSC remain open to additional classes in the future to provide much needed flexibility to the program. The commenter did not identify any classes that the state may wish to add.

Response: HHSC is unsure what program flexibility would result from adding additional classes, and HHSC may not wish to classify hospitals for this program in a way that would result in inconsistent treatment across reimbursement programs. However, HHSC will consider amending the rule in the future to add other classes if there is a good public policy reason to do so. No changes were made to the rule in response to this comment.

Comment: One commenter noted that teaching hospitals are not included as a class and should not be excluded from directed payments.

Response: Teaching hospitals are not proposed to be a separate class in this program, but they are not excluded from directed payments. Some are classified for this program as they are for the DSH or UC programs (e.g., state-owned or urban public); but if not, they fall within the "all other hospitals" classification. No changes were made to the rule in response to this comment.

Comment: One commenter suggested that HHSC revise the proposed list of eligible classes in subsection (c)(1) to include non-acute care hospitals, long-term-acute care hospitals, and rehabilitation hospitals.

Response: This suggestion appears to be based on the fact that Medicaid reimbursement to these hospital types uses a different methodology than is used to reimburse other hospital types. However, it appears that including these hospital types in the "all other hospitals" classification will have a minimal impact on funding for the program and does not justify the creation of additional classes in this program. HHSC will consider creating additional classes of hospital through notice-and-comment rulemaking in the future if there appears to be a good public policy reason to do so. No changes were made to the rule in response to this comment.

Comment: One commenter asked that language be included in subsection (c)(1) to make the rate-increase directive in HHSC's contract with MCOs contingent on receipt of funds through IGTs and adjustment of premiums paid to the MCO accounting for the rate increase.

Response: The requested change in the rule is unnecessary because the premium amounts will not be calculated and the rate-increase directions will not be included in the MCO contracts until after the funds are transferred to HHSC by the sponsoring governmental entities. The need to adjust premiums from the contracted amount will never be triggered. If HHSC does not have the IGT by the deadline described in the rule, the SDA will not participate in the rate-increase program during the contract period. No changes to the rule were made in response to this comment.

Comment: One commenter recommended that language be added to subsection (c)(1) to clarify that HHSC may direct payments through contracts with MCOs only in SDAs that are participating in the program described in this rule.

Response: HHSC agrees that the requested change to subsection (c)(1) would clarify the rule. The rule was revised in response to this comment.

Comment: One commenter asked HHSC to revise subsection (c)(1) to clarify that the rate increase is subject to the MCOs' established rate payment rules and that a hospital cannot claim the enhanced payment apart from the underlying claim.

Response: HHSC agrees that a hospital cannot claim the enhanced payment apart from the underlying claim, but does not think the requested change to the rule is necessary. The title and other language of the rule clearly indicate that the program allows HHSC to direct an MCO to increase its contracted rates with hospitals for providing certain Medicaid services. The rule does not otherwise intrude upon or interfere with all other applicable MCO rate payment activities. No changes were made to the rule in response to this comment.

Comment: One commenter requested clarification on whether the directed rate increase applies to payment for services based on the contract status of the hospital at the time the service was performed or the time the claim is submitted. For example, if an MCO terminates its contract with a hospital midway through the program period, would the increased rate apply to claims submitted during the program period but after the date the contract was terminated?

Response: Neither the rule nor the contract language directing the rate increase are intended to modify other managed-care payment rules or to impact other provisions of the contracts between the MCO and its network hospitals. Whatever managed-care payment rules or contract provisions that apply to the base rate apply equally to the directed rate increase. The MCO and hospital should not treat the increased portion of the contracted rate any differently than the base rate for purposes such as payment for claims submitted after the date that the MCO/hospital contract was terminated. No changes were made to the rule in response to this comment.

Eligibility

Comment: One commenter requested that HHSC revise the rate increase eligibility criteria to include an additional consideration-amount of non-federal share funding available from governmental entities. According to the commenter, HHSC must take the amount of available funding into account when determining the classes of hospitals eligible for the rate increase because HHSC has specified that funding for the non-federal share of the increase must come from sponsoring governmental entities.

Response: HHSC disagrees with the commenter that the amount of available funding should be part of the determination of class eligibility. HHSC believes that the amount of IGT the sponsoring governmental entities propose to transfer is relevant to and should be part of the determination of the percentage of rate increase that will be applicable to one or more classes of hospital. This determination is in subsection (f)(1) of the rule. For this reason, HHSC declines to revise the rule as the commenter suggests.

Comment: Some commenters noted that subsection (d) fails to clarify that access to IGT cannot be the sole basis for determining whether a hospital class is eligible to receive a rate increase, thereby violating CMS's prohibition against "pay-to-play" arrangements. They suggested adding new subparagraph (d)(2)(D) that would read: "No eligibility determination shall be made solely based on a hospital class' ability or inability to secure public funding." Otherwise, according to the commenters, the rule could permit a scenario in which select hospitals receive a rate increase solely due to their access to IGT while others classes lacking access to IGT are excluded entirely.

Response: HHSC disagrees and declines to revise the rule as the commenters suggest. The rule appropriately lays out how HHSC will determine eligibility for rate increases by service delivery area and class of hospital.

Services subject to rate increase

Comment: Commenters encouraged HHSC to revise subsection (e) to ensure that rate increases apply equally to in-network and out-of-network services. They reasoned that if rate increases are limited to in network providers and/or services, this may provide an incentive for participating MCOs to eliminate or limit in-network services to avoid having to increase rates. One of the commenters argued that, although the federal Medicaid managed care rules specify that uniform percentage rate increases apply "for network providers," this language does not preclude mandatory rate increases from applying also to non-network providers.

Response: HHSC disagrees and declines to revise the rule as the commenters suggest as HHSC does not want to encourage or reward hospitals choosing to operate in an out-of-network capacity.

Comment: Several commenters objected to allowing HHSC to direct rate increases for a subset of inpatient and/or outpatient services and suggested the rule be revised accordingly. According to these commenters, carving out certain services from the rate increase would significantly increase the MCOs' administrative burden. Some commenters specifically mentioned and objected to carving out non-emergent services provided in emergency departments.

Response: HHSC declines to revise the rule as the commenters suggest. HHSC should have the flexibility to direct the rate increase in a way that furthers HHSC goals and priorities.

Determination of percentage of rate increase

Comment: One commenter suggested that HHSC add overall market dynamics and competitiveness as a factor in setting the percent increase applicable to each class. The commenter attributed this suggestion to its belief that HHSC, in implementing a supplemental rate increase program, should avoid influencing the underlying contractual arrangements and incentives between hospitals and MCOs.

Response: HHSC agrees with the commenter that hospital market dynamics within the SDA is an appropriate factor for HHSC to consider when setting the percent increase. Therefore, HHSC revised subsection (f)(1) by changing subparagraph (F) to "hospital market dynamics within the SDA" and moving "other HHSC goals and priorities" to subparagraph (G).

Comment: One commenter asked HHSC to revise subsection (f)(1) to limit the percentage rate increase to no more than the amount of IGT the sponsoring governmental entities propose to transfer.

Response: HHSC agrees to limit the percentage rate increases that the MCOs are directed to pay contracted hospitals to no more than the levels that are supported by the amount of IGT proposed to be transferred to HHSC by the sponsoring governmental entities. However, nothing in the rule may be construed to limit the authority of HHSC to require sponsoring governmental entities to transfer additional funds to the state following the reconciliation process described in §353.1301(g), if the amount previously transferred is less than the non-federal share of the amount expended by HHSC in the SDA for this program. Subsection (f) of the rule was revised in response to this comment.

Comment: Commenters suggested that in determining the percentage of rate increase, HHSC consider input from stakeholders other than just the sponsoring governmental entities. One of these commenters added that the MCOs input should be considered, as well as input from the other stakeholders.

Response: HHSC agrees with this comment. HHSC expects the hospitals, MCOs, and sponsoring governmental entities within an SDA to work cooperatively in developing a proposal to bring to HHSC. Subsection (f) was revised to clarify that HHSC will consider information from "the participants in the SDA (including hospitals, managed-care organizations, and sponsoring governmental entities)." Additionally, HHSC revised subsection (g) to add a description of the application process that initiates an SDA's request to participate in this program. The new language in subsection (g) includes a provision that the stakeholders in the SDA are expected to work cooperatively to complete the application.

Application process; timing and amount of transfer of non-federal share

Comment: Commenters suggested that HHSC allow sponsoring governmental entities to participate in UHRIP as soon as possible, pending CMS approval. At a minimum, sponsoring governmental entities should be allowed to enter the program mid-year, especially during the first year of the program.

Response: HHSC agrees with the commenters that if an SDA is not able to participate in UHRIP beginning September 1, they should be able to enter the program mid-year, i.e. on March 1. To accomplish this change, the definition of "program period" in subsection (b)(6) of the rule was revised. As adopted, "program period" is defined as a period of time for which HHSC will contract with participating MCOs to pay increased capitation rates for the purpose of provider payments under this section. Each program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year. A service delivery area that is unable to participate in the program described in this section beginning September 1 may apply to participate beginning March 1 of the program period and ending August 31. Participation during such a modified program period is subject to the application and intergovernmental-transfer deadlines described in subsection (g) of this section.

Comment: Some commenters requested that HHSC delay the May 1 deadline for the initial transfer of the non-federal share. They said that requiring IGT so far in advance of receiving the rate enhancement could cause sponsoring governmental entities significant financial hardship. Another commenter requested that any SDA with Local Provider Participation Funds (LPPF) legislation pending be given a one-time exception to the May 1 deadline for completing the IGT; their deadline would be July 1. The commenter posited that, if the legislation fails and the SDA cannot complete the IGT by July 1, HHSC has sufficient time to submit a revised MCO contract to CMS to remove the UHRIP rate for the SDA.

Response: CMS approval is a prerequisite to implementation of the program, and the description of the program provided to CMS said that "[f]unds to support the non-federal share of the first six months of an annual [per member per month (PMPM)] increase would be transferred to HHSC no later than four months prior to the effective date of the increased PMPM." This timeline reflects the fact that September 1 PMPMs must be finalized internally by HHSC by June 15 of each calendar year in order to meet all CMS deadlines. The commenters' proposal to delay the initial transfer

of the non-federal share is inconsistent with the timeline provided to CMS. Delaying the first IGT as the commenters request would likely also delay the start of the program.

Therefore, as proposed, SDAs must complete the IGT for the first six months of the program period no later than May 1. However, the rule language has been revised to say "four months prior to the start of the program period" rather than "May 1 of the calendar year that also contains the first month of the program period." This change is to reflect the ability of an SDA to commence participation in UHRIP on March 1. In such circumstances, HHSC must receive the IGT no later than November 1.

HHSC would point out that the deadline for submitting IGT for QIPP is later than the deadline for UHRIP (May 31 rather than May 1). This difference is attributable to how the two programs are structured. Furthermore, identical timelines for the two programs would substantially complicate staff's ability to successfully implement them in time for a September 1 start date.

As for financial hardship an SDA might experience given the time between IGT and capitation payments, it is worth noting that participation in UHRIP is voluntary, and sponsoring governmental entities are able to determine the amount of funding to transfer to HHSC. If a certain level of funding would cause financial hardship for a sponsoring governmental entity, the entity can participate at a lower level.

Comment: One commenter requested that HHSC revise subsection (g) to require only three months' worth of IGT in May, with monthly IGTs beginning in August. Additionally, the commenter requested that the March 1, 2017, deadline for SDAs to submit applications for rate increases (which was not in the rule as proposed but was widely communicated to stakeholders through face-to-face meetings, emails, webpage postings, hospital association communications, and conference calls) be moved to September 1, 2017.

Response: Regarding the commenter's request to delay half of the initial IGT until August, HHSC declines to revise the rule as the commenter suggests. As the previous response explained, the timing of the first IGT has been communicated to CMS, and it is necessary given HHSC's rate setting schedule. The PMPMs must be finalized in June, and they cannot be finalized until HHSC has the required IGT funds in hand.

HHSC did not revise its policy regarding the March 1 application deadline in response to this comment. However, subsection (g) of the rule was revised for adoption to describe the SDA application process and specify that HHSC must receive the completed application no later than six months before the beginning of the program period or modified program period in which the SDA proposes to participate. This deadline is necessary to enable HHSC to submit proposals to CMS for approval before the beginning of the program year; to enable HHSC to gauge the total estimated expenditures for the program statewide; to allow HHSC actuaries to calculate the capitation rates that will be included in HHSC's MCO contracts; and to begin the process of amending MCO contracts to include the directed rate increases. HHSC cannot wait until the beginning of the program period (or modified program period) to begin the lengthy process required to make managed care capitation payments and directed rate increases.

Comment: One commenter suggested that HHSC allow some type of commitment (e.g., establishment of a dedicated account or a line of credit) from the transferring entity with no immediate transfer of funds; this would allow the IGT to occur closer to the September 1 start date. Also, rather than require one large IGT to cover six months of the program, the commenter proposed allowing more frequent transfers of smaller amounts to minimize the amount of funds tied up for long periods of time.

Response: HHSC declines to revise the rule as the commenter suggests. Consistent with the new federal rule, no network provider hospital's participation will be conditioned on the provision of an IGT, nor on its entering into or adhering to an IGT commitment or agreement. The commenter's other suggestion (that HHSC allow more frequent transfers of smaller amounts) is one that may be revisited in the future.

Comment: Commenters encouraged HHSC to revise subsection (g) to provide greater clarity regarding the timing, amount, and notice of additional IGTs. They expressed concern whether HHSC will provide adequate advance notice of additional IGT requests. Some commenters proposed that, rather than require the second six months of IGT in November, HHSC accept a letter of credit for the second 6-month amount and require just one month of IGT in November. The governmental entity would then IGT for one month at the beginning of December, and for the remaining four months at the beginning of January.

Response: HHSC desires to maintain flexibility for the second six months of IGT, but revised the adopted rule to indicate that the second six months are due no later than November 1 of the calendar year. HHSC will provide adequate advance notice of the date(s) and amount(s) of subsequent transfers. It cannot, however, accept a letter of credit in lieu of funds.

Comment: Some commenters suggested that HHSC revise subsection (g) to limit the use of additional required IGTs to (1) the sponsoring governmental entity's SDA and (2) to rate increases under this Subchapter.

Response: While these parameters may not be stated explicitly, they are implicit in the rule. Funds for one SDA will not be used in another SDA, and funds for UHRIP will not be used for any other purpose. No changes were made to the rule in response to this comment.

Comment: Some commenters suggested that HHSC revise subsection (g) to remove the 10% add-on to the IGT amount because the additional funds will put a significant burden on many sponsoring governmental entities in both urban and rural service delivery areas.

Response: The extra 10% that will be built into HHSC's IGT requests is necessary to ensure that, if expenditures are greater than what was estimated because of increased enrollment, there will be enough funds to support the resulting capitation payments. For this reason, HHSC declines to revise the rule as the commenters suggest.

General comments on the rule

Comment: Commenters expressed support for the proposal as a much-needed way to facilitate uniform rate increases in Medicaid managed care.

Response: HHSC appreciates comments in support of the proposal. No changes were made to the rule in response to the comments.

Comment: One commenter asked HHSC to adopt a uniform model or methodology in order to limit administrative costs, promote efficiency, reduce confusion, and ensure alignment with defined quality goals. The commenter stated that administer-

ing multiple models by SDA increases the likelihood of conflict between hospitals and MCOs.

Response: HHSC understands this comment to request uniformity among all participating SDAs in identifying the classes of hospital eligible for rate increases, the percentage rate increase applicable to each class, and the services subject to the rate increase. While some efficiencies could be achieved through such uniformity, HHSC believes those efficiencies are significantly outweighed by the benefits of allowing each SDA the flexibility to propose a program that works best for the participants in their region. SDAs in the state differ significantly in several important ways, including availability of funding for healthcare, number of Medicaid hospitals, and number of potential sponsoring governmental entities. The stakeholders in each region, working cooperatively together, are better suited than is HHSC to determine whether and how a uniform rate increase program should be structured for the benefit of the stakeholders and the Medicaid population of the region. No changes were made to the rule in response to this comment.

Comment: Commenters noted that the proposed rule references a "quality strategy" and recommended that if quality measures will be used to determine payment amounts, the rule should be revised to require that such measures be developed collaboratively by sponsoring governmental entities and hospitals. One of these commenters also requested collaboration with statewide hospital associations in developing quality metrics.

Response: To obtain CMS approval of a directed payment program such as UHRIP in each SDA, the state is required by federal regulation to show how the program is expected to advance at least one of the goals and objectives in the state's quality strategy. See 42 C.F.R. §438.6(c)(2). Texas' quality strategy is contained in Appendix D of the Section 1115 Demonstration waiver. The quality strategy identifies "creating provider incentive programs" as one of the state's goals. The state anticipates that increased hospital payment rates through this program will act as an incentive for hospitals to continue participation in the Medicaid program while strengthening their ability to provide inpatient and outpatient services to Medicaid clients in the communities in which they are located.

It is in this context that the proposed rule authorizes HHSC to consider the goals and objectives in HHSC's quality strategy, among other things, when determining classes of hospital eligible for a rate increase and the services subject to the rate increase. Since the quality strategy has already been developed, there is no need for SDA participants to collaborate as proposed by these commenters. Quality measures and metrics will not be used to determine payment amounts to individual hospitals. No changes were made to the rule in response to this comment.

Comment: Multiple commenters noted that not all areas of the state may be able to reach consensus on the details of a rate increase in their region in time to implement the program on September 1, 2017, but asked HHSC to allow the rate increases to go forward in SDAs that have demonstrated readiness. One of the commenters suggested not finalizing the rule while policy discussions continue, but moving forward with the rate increases in SDAs that have consensus, even if the rule is not finalized.

Response: HHSC does not agree that it would be appropriate to implement a directed rate increase program if the administrative rule codifying HHSC's policies has not been adopted. HHSC and many stakeholder groups have worked diligently toward a September 1, 2017, implementation date. For these reasons, HHSC will not delay adoption of the rule pending further discussions with stakeholders. HHSC will implement the program on September 1, 2017, in SDAs that have met the program requirements described in this rule and in §353.1301, and if CMS has approved the program in those areas. HHSC will continue to work with all interested stakeholders and will consider proposals to amend the rule in the future, if there are good public-policy reasons to do so.

Comment: Several commenters asked if the rules as proposed require all of the MCOs and network hospitals in a SDA to participate in the uniform rate increase before such an increase can occur in that SDA.

Response: Subsection (g)(1)(A) states HHSC's expectation that the stakeholders in the SDA, including hospitals, sponsoring governmental entities, and MCOs, will work cooperatively to complete the application for participation. HHSC will not look favorably on applications lacking MCO support.

Comment: Several commenters asked for clarification of how HHSC will calculate the hospital specific limit (HSL) as part of the calculation for the uniform rate increases. They cited the injunction in Texas Children's Hospital's lawsuit against CMS which prohibits CMS from using the methodology set out in Frequently Asked Question 33 in the treatment of third-party payments in calculating HSLs.

Response: HHSC follows the methodology in Frequently Asked Question 33 when calculating the HSL and will do so in the context of calculating the uniform rate increases.

Comment: One commenter expressed concern that significant rate increases for outpatient services would provide incentives to hospitals to advertise their emergency departments and encourage inappropriate utilization.

Response: HHSC currently limits payments for non-emergent care provided in an emergency department to 125 percent of its doctor's office visit fee as a method of incentivizing hospitals to divert such care from expensive emergency departments to lower-cost settings such as clinics. HHSC agrees with the commenter that applying a rate increase to these services would reduce the strength of that incentive. For that reason, it is currently HHSC's intent to direct MCOs in SDAs participating in UHRIP to exclude non-emergent care provided in emergency departments from the rate increase. However, HHSC believes it is appropriate to retain the discretionary language in the rule for HHSC to determine which services or subsets of services should be subject to the rate increase. No changes to the rule were made in response to this comment.

Comment: Some commenters asked HHSC to provide flexibility in the rules to allow MCOs to contract with hospitals using alternative payment models (APMs).

Response: Under the rule, HHSC will direct an MCO in a participating SDA to increase the rate that it would otherwise pay a hospital for providing certain services. HHSC does not believe the rule precludes the parties contracting to use an alternative payment model for the services subject to the rate increase, as long as payment to the hospital for the subject services is increased by the designated percentage. However, because it is a uniform rate increase to what would otherwise be paid for the subject services, the MCO and hospital may not develop an alternative payment model that is applied only to the increase in the capitation payment to the MCO. In other words, the APM

must apply to the complete payment for the service; not just to the portion of the payment added under this rule.

No changes were made to the rule in response to this comment. However, HHSC welcomes continued dialogue with MCOs and hospitals to gain insight into the impact of this program on efforts to develop alternative payment models. HHSC will consider amending the rule in the future if necessary to facilitate alternative payment models.

Comment: One commenter asked that HHSC clarify that the rule does not override performance or quality-based arrangements in MCO contracts with hospitals.

Response: The rule does not modify or impact provisions of the contracts between the MCO and its network hospitals, except that the rate for subject services is increased from what it would otherwise be. Whatever contract provisions apply to the base rate apply equally to the directed rate increase. The MCO and hospital should not treat the increased portion of the contracted rate any differently than the base rate for purposes such as performance or quality-based arrangements. No changes were made to the rule in response to this comment.

Comment: Several commenters noted that UHRIP puts MCOs at significant risk based on the magnitude of the proposed rate increases. One commenter also expressed concern that some MCOs will have challenges with increased capitation payments of the proposed magnitudes because of Texas Department of Insurance risk-based capital requirements.

Response: These do not appear to be a comments on the proposed rule, but rather on the potential impact to MCOs of the significant IGT amounts and rate increase percentages that are being proposed in some SDAs. HHSC expects the stakeholders in the SDA, including hospitals, sponsoring governmental entities, and MCOs, to work cooperatively to develop the information that is submitted to HHSC on the SDA's application. Hospitals and governmental entities in an SDA should give careful consideration to the potential risks or negative impacts to the MCOs of the proposed level of funding. After receiving the applications, HHSC commits to communicating with SDA participants before final directed rate increases are finalized and to considering the perspectives of all participating entities, including the MCOs, on the level of increases that can and should be implemented in the SDA. No changes were made to the rule in response to this comment.

Comment: One commenter recognized that the IGT sources, mix of hospitals, and funding arrangements between the MCOs and hospitals may differ by service area and recommended that the final HHSC regulation allow for variation.

Response: HHSC agrees with this comment and believes that the final rule as amended provides for flexibility for SDAs to develop a program structured for the benefit of the stakeholders and the Medicaid population of their regions.

Comment: One commenter noted that HHSC will soon release new requirements for MCOs related to minimum percentages of payments that are not based on traditional fee-for-service rates. MCOs are currently engaged in developing payment arrangements that include incentive payments, shared savings and risk arrangements, and sub-capitation arrangements. The commenter questioned how the proposed UHRIP rule aligns with the value-based reimbursement arrangements the MCOs will soon be required to implement.

Response: HHSC does not believe the UHRIP rule is inconsistent with other HHSC managed-care policies and requirements because it does not preclude the MCOs and hospitals contracting to use an alternative payment model for the services subject to the rate increase, as long as payment to the hospital for the subject services is increased by the designated percentage. For example, if an MCO and hospital agreed on a sub-capitation model, HHSC would expect the sub-capitation payment amount to be increased by the directed percentage. The rule also does not preclude shared savings arrangements, but it does preclude shared risk arrangements because any return of a payment from the hospital to the MCO would necessarily mean that the final payment for the service was not increased by the percentage directed in HHSC's contract with the hospital.

No changes to the rule were made in response to this comment. However, HHSC commits to coordinating with the agency's Medicaid CHIP staff to ensure that the policies articulated in this rule are not inconsistent with other directions or requirements imposed on Medicaid MCOs.

Comment: Some commenters asked for clarification on how the money that is transferred to HHSC will be transferred back to the hospitals that submitted it. The commenters asked how a low volume rural hospital can ensure that it will receive any level of return on its transferred funds and whether the governmental entity might then be at risk.

Response: A governmental entity's decision to participate in UHRIP in the SDA in which the entity is located, including the decision to transfer funds to HHSC and the amount of any such transfer, is completely voluntary. Once the entity's funds are transferred and combined with funds from other sponsoring governmental entities in the SDA, they are used to increase capitation payments to all of the MCOs in the SDA to support rate increases to all contracted hospitals in the classes designated for an increase. There is no formula in the rule or otherwise that guarantees the public hospital will receive increased managed care payments in an amount equal to or greater than the amount of the IGT. HHSC urges participants in the SDA to work together cooperatively to propose a plan for the SDA that mitigates the risks to the stakeholder groups, including the governmental entities and MCOs. No changes were made to the rule in response to this comment.

Comment: Some commenters stated that the rule is economically discriminatory because urban areas of the state with high property values and high Medicaid volumes have been carved out into their own regions. The commenters stated that the proposed regions do not correspond to any other regional system in Texas, including transformational waiver regions, and that the map appears to be gerrymandered, resulting in regions with very little available IGT. The commenters asked how HHSC will manage these regions and how hospitals who choose not to make IGTs will be treated.

Response: HHSC disagrees with this comment. HHSC did not create regions in the state for purposes of directing MCOs to increase hospital payment rates under the UHRIP program; instead, HHSC uses the long-standing HHSC-defined service areas that are applicable to each MCO program and within which each MCO has been selected to provide MCO services. HHSC publishes information on the managed care service areas, including a map of all of the counties in each service area, the MCO programs that are active in each SDA, and the MCOs with which HHSC contracts to provide services in each SDA. The information is available on HHSC's

website at: https://hhs.texas.gov/sites/hhs/files/...chip/.../Managed-Care-Service-Areas-Map.pdf.

The rule is not discriminatory because some areas of the state have greater IGT availability. At this time, general revenue has not been appropriated to HHSC for this purpose. HHSC cannot require local governmental entities to transfer funds to support this program. The transfer of funds is completely voluntary by the sponsoring governmental entities. No changes to the rule were made in response to this comment.

Comment: A few commenters suggested that the state should pay rural hospitals based on cost, as the Medicare program does.

Response: Rural hospitals in Texas are already paid closer to cost for providing Medicaid services than are urban hospitals. Consequently, their Medicaid shortfall (i.e., the difference between the cost of providing the service and the payment for the service) is less than it is, on average, for hospitals in urban areas. No changes to the rule were made in response to this comment.

Comment: Some commenters complained that Medicaid funding is being diverted through private, non-hospital organizations in which rural and community hospitals participate. According to the commenters, the allocation of funding is kept secret and is likely under the control of private consultants. Rural and community hospitals should be allowed to IGT on behalf of private hospitals subject to their funding availability.

Response: While this is not a comment on the proposed rule, HHSC believes these complaints warrant a response. These complaints are apparently directed at funding arrangements in which the rural hospitals and governmental entities voluntarily participate. HHSC emphasizes that a governmental entity's decision to provide an IGT to support UHRIP or other supplemental payment programs is completely voluntary and the governing boards of the hospitals and governmental entities are fully responsible for the decisions they make on the use of the public funds entrusted to them. If a governmental entity cannot determine how its funds are being used; if there are secret allocations under the control of private consultants; or if funds are being diverted through private organizations, those are not as a result of any HHSC rule or policy and not within the knowledge or control of HHSC. If state or federal rules are being violated, HHSC should be informed, but these complaints and comments do not identify any such violation. No changes were made to the rule in response to this comment.

Comment: Some commenters alleged that HHSC had provided certain consultants a substantial head start on securing lucrative arrangements in some areas of the state.

Response: While this is not a comment on the proposed rule, HHSC believes this allegation warrants a response. HHSC did not provide a "head start" to certain consultants. HHSC is sometimes approached by outside parties who propose Medicaid reimbursement methodologies or programs for HHSC's consideration. Doing so is entirely appropriate and HHSC is interested in hearing about methodologies to increase and improve hospital funding for Medicaid services. In this case, the original idea that later developed into UHRIP was presented to HHSC by representatives of one SDA as a possible pilot project. HHSC then began discussions with CMS to determine whether CMS would be amenable to such a program. Interest in the program grew in other areas of the state and HHSC published the proposed rules at the beginning of this year to open the program for comment from any interested person or party.

Changes from the proposed version that are not in response to comments

The following changes to the final rule from the proposed version were made by HHSC to improve or clarify the rule from the proposed version, and not in response to a comment:

The title of §353.1305 was changed from "Regional Uniform Rate Increases for Hospital Services" to "Uniform Hospital Rate Increase Program" for clarity and simplicity.

Subsection (c)(1) was revised to delete "institutions for mental diseases" (IMDs) as a class of hospital eligible to receive rate increases under this program. This revision was made based on limitations in federal law on the amount of federal matching funds available for payments to IMDs.

Subsection (g) was revised to add a description of the process for an SDA to submit an application to the state for participation in the program described in this rule.

STATUTORY AUTHORITY

The new rule is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code, Chapter 32; and with Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

§353.1305. Uniform Hospital Rate Increase Program.

(a) Introduction. This section describes the circumstances under which HHSC directs an MCO to provide a uniform percentage rate increase to hospitals in the MCO's network in a designated service delivery area for the provision of inpatient services, outpatient services, or both. This section also describes the methodology used by HHSC to calculate and administer such rate increase.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this and other sections of this subchapter may be defined in §353.1301 of this subchapter (relating to General Provisions).

(1) Children's hospital--A Medicaid hospital designated by Medicare as a children's hospital.

(2) Inpatient hospital services--Services ordinarily furnished in a hospital for the care and treatment of inpatients under the direction of a physician or dentist, or a subset of these services identified by HHSC. Inpatient hospital services do not include skilled nursing facility or intermediate care facility services furnished by a hospital with swing-bed approval, and any other services that HHSC determines should not be subject to the rate increase.

(3) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.

(4) Non-urban public hospital--

(A) A hospital owned and operated by a governmental entity, other than a hospital described in paragraph (8) of this subsection, defining rural public hospital, or a hospital described in paragraph (10) of this subsection, defining urban public hospital; or

(B) A hospital meeting the definition of rural public-financed hospital in §355.8065(b)(37) of this title (relating to Disproportionate Share Hospital Reimbursement Methodology), other than a hospital described in paragraph (7) of this subsection defining rural private hospital.

(5) Outpatient hospital services--Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients of a hospital under the direction of a physician or dentist, or a subset of these services identified by HHSC. HHSC may, in its contracts with MCOs governing rate increases under this section, exclude from the definition of outpatient hospital services such services as are not generally furnished by most hospitals in the state, or such services that HHSC determines should not be subject to the rate increase.

(6) Program period--A period of time for which HHSC will contract with participating MCOs to pay increased capitation rates for the purpose of provider payments under this section. Each program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year. A service delivery area that is unable to participate in the program described in this section beginning September 1 may apply to participate beginning March 1 of the program period and ending August 31. Participation during such a modified program period is subject to the application and intergovernmental-transfer deadlines described in subsection (g) of this section.

(7) Rural private hospital--A privately-operated hospital located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated rural referral center, a sole community hospital, or a critical access hospital.

(8) Rural public hospital--A hospital that is owned and operated by a governmental entity and is located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated rural referral center, a sole community hospital, or a critical access hospital.

(9) State-owned hospital--A hospital that is owned and operated by a state university or other state agency.

(10) Urban public hospital--A hospital that is operated by or under a lease contract with one of the following entities: the Dallas County Hospital District, the El Paso County Hospital District, the Harris County Hospital District, the Tarrant County Hospital District, the Travis County Healthcare District dba Central Health, the University Health System of Bexar County, the Ector County Hospital District, the Lubbock County Hospital District, or the Nueces County Hospital District.

(c) Classes of participating hospitals.

(1) HHSC may direct the MCOs in a service delivery area that is participating in the program described in this section to provide a uniform percentage rate increase to all hospitals within one or more of the following classes of hospital with which the MCO contracts for inpatient or outpatient services:

(A) children's hospitals;

(B) non-urban public hospitals;

(C) rural private hospitals;

(D) rural public hospitals;

(E) state-owned hospitals;

(F) urban public hospitals; and

(G) all other hospitals, except institutions for mental diseases.

(2) If HHSC directs rate increases to more than one class of hospital within the service delivery area, the percentage rate increases directed by HHSC may vary between classes of hospital.

(d) Eligibility. HHSC determines eligibility for rate increases by service delivery area and class of hospital.

(1) Service delivery area. Only hospitals in a service delivery area that includes at least one sponsoring governmental entity are eligible for a rate increase.

(2) Class of hospital. HHSC will identify the class or classes of hospital within each service delivery area described in paragraph (1) of this subsection to be eligible for a rate increase. HHSC will consider the following factors when identifying the class or classes of hospital eligible for a rate increase and the percent increase applicable to each class:

(A) whether a class of hospital contributes more or less significantly to the goals and objectives in HHSC's quality strategy, as required in 42 C.F.R. §438.340, relative to other classes;

(B) which class or classes of hospital the sponsoring governmental entity wishes to support through intergovernmental transfers (IGTs) of public funds, as indicated on the application described in subsection (g) of this section; and

(C) the percentage of Medicaid costs incurred by the class of hospital in providing care to Medicaid managed care clients that are reimbursed by Medicaid MCOs prior to any uniform rate increase administered under this section.

(e) Services subject to rate increase. HHSC may direct the MCOs in a service delivery area to increase rates for all or a subset of inpatient services, all or a subset of outpatient services, or all or a subset of both, based on the service or services that will best advance the goals and objectives of HHSC's quality strategy.

(f) Determination of percentage of rate increase.

(1) In determining the percentage of rate increase applicable to one or more classes of hospital, HHSC will consider the following factors:

(A) information from the participants in the SDA (including hospitals, managed-care organizations, and sponsoring governmental entities) on one or both of the following, as indicated on the application described in subsection (g) of this section:

(i) the amount of IGT the sponsoring governmental entities propose to transfer to HHSC to support the non-federal share of the increased rates for the first six months of a program period; and

(ii) the percentage rate increase the SDA participants propose for one or more classes of hospital for the first six months of a program period;

(B) the class or classes of hospital determined in subsection (d)(2) of this section;

(C) the type of service or services determined in subsection (e) of this section;

(D) actuarial soundness of the capitation payment needed to support the rate increase;

(E) available budget neutrality room under any applicable federal waiver programs;

(F) hospital market dynamics within the SDA; and

(G) other HHSC goals and priorities.

(2) HHSC will limit the percentage rate increases determined pursuant to this subsection to no more than the levels that are supported by the amount described in paragraph (1)(A)(i) of this subsection. Nothing in this section may be construed to limit the authority of the state to require the sponsoring governmental entities to transfer additional funds to HHSC following the reconciliation process described in section 353.1301(g) of this title, if the amount previously transferred is less than the non-federal share of the amount expended by HHSC in the SDA for this program.

(3) After determining the percentage of rate increase using the process described in paragraphs (1) and (2) of this subsection, HHSC will modify its contracts with the MCOs in the service delivery area to direct the percentage rate increases.

(g) Application process; timing and amount of transfer of non-federal share.

(1) The stakeholders in a service delivery area initiate the request for HHSC to implement a uniform hospital rate increase program by submitting an application using a form prescribed by HHSC.

(A) The stakeholders in the service delivery area, including hospitals, sponsoring governmental entities, and MCOs, are expected to work cooperatively to complete the application.

(B) The application provides an opportunity for stakeholders to have input into decisions about which classes of hospital and services are subject to the rate increases, and the percentage rate increase applicable to each class, but HHSC retains the final decision-making authority on these aspects of the program following the processes described in subsections (d) - (f) of this section.

(C) HHSC must receive the completed application no later than six months before the beginning of the program period or modified program period in which the SDA proposes to participate.

(D) HHSC will process the application, contact SDA representatives or stakeholders if there are questions, and notify the stakeholders in the SDA of its decisions on the application, including the classes of hospital eligible for the rate increase, the services subject to the increase, the percentage rate increase applicable to each class, and the total amount of IGT required for the first six months of the program period.

(2) Sponsoring governmental entities must complete the IGT for the first six months of the program period no later than four months prior to the start of the program period, unless otherwise instructed by HHSC. For example, for the program period beginning September 1, 2017, HHSC must receive the IGT for the first six months no later than May 1, 2017; for the modified program period beginning March 1, 2018, HHSC must receive the IGT no later than November 1, 2017.

(3) Following the transfer of funds described in paragraph (2) of this subsection, sponsoring governmental entities must transfer additional IGT at such times and in such amounts as determined by HHSC to be necessary to ensure the availability of funding of the non-federal share of the state's expenditures under this section and HHSC's compliance with the terms of its contracts with MCOs in the service delivery area. In no event may transfers for directed increases in a program period occur later than November 1 of the calendar year.

(4) HHSC will instruct sponsoring governmental entities as to the required IGT amounts. Required IGT amounts will include all costs associated with the uniform rate increase, including costs associated with premium taxes, risk margins, and administration, plus ten percent.

(h) Effective date of rate increases. HHSC will direct MCOs to increase rates under this section beginning the first day of the program period that includes the increased capitation rates paid by HHSC to each MCO pursuant to the contract between them.

(i) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during the program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(j) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(k) of this subchapter.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on March 20, 2017.

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Karen Ray
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Texas Health and Human Services Commission
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Proposal publication date: January 20, 2017
For further information, please call: (512) 707-6079

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~~TITLE 19. EDUCATION~~

~~PART 2. TEXAS EDUCATION AGENCY~~

~~CHAPTER 53. REGIONAL EDUCATION SERVICE CENTERS~~

~~SUBCHAPTER AA. COMMISSIONER'S RULES~~

~~19 TAC §53.1001~~

~~The Texas Education Agency adopts an amendment to §53.1001, concerning regional education service center board of directors. The amendment is adopted without changes to the proposed text as published in the January 20, 2017, issue of the *Texas Register* (42 TexReg 186) and will not be republished. The adopted amendment allows State Board of Education members to serve as board of trustees members for regional education service centers.~~

~~REASONED JUSTIFICATION. The Texas Education Code, §8.003, requires the commissioner to adopt rules concerning the selection of members of the boards of trustees for regional education service centers. To implement the statute, 19 TAC §53.1001 was adopted effective September 1, 1998, setting out the requirements for members of the board of directors of regional education service centers. The adopted amendment allows members of the State Board of Education to be members of the boards of directors of regional education service centers and will ensure that more individuals with experience in education can serve as members of the boards of directors of regional education service centers.~~

~~SUMMARY OF COMMENTS AND AGENCY RESPONSES. The public comment period on the proposal began January 20, 2017, and ended February 21, 2017. Following is a summary of public comments received and corresponding agency~~