PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

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 Services Commission (HHSC) proposes new Subchapter O, Delivery System and Provider Payment Initiatives, §353.1301, concerning General Provisions.

BACKGROUND AND JUSTIFICATION

This proposed new rule describes certain general provisions that 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.

All such provisions of the rule are described in the section-by-section summary below. However, HHSC believes four provisions of the rule require additional explanation: reconciliation of the non-federal share, disallowance of federal funds, recoupment, and the state's cost of administering programs authorized under Subchapter O.

The reconciliation provision describes the same process previously used for other enhanced payment programs. The programs included in this subchapter are funded with intergovernmental transfers (IGTs). Since actual expenditures are based on MCO member enrollment, which may fluctuate, HHSC initially requires governmental entities to transfer 10% more non-federal funds than anticipated in order to protect state general revenue in the event that member months increase beyond that which is expected. If there is no increase in member months, or the increase in cost due to increased member months does not go beyond 10%, the difference is returned to the governmental entity that transferred the non-federal funds. If, however, the increase in cost due to increased member months does go beyond 10%, HHSC will require additional funds from the governmental entities.

The disallowance provision describes the actions HHSC will take in the event of a disallowance of federal funds by CMS related to payments under this subchapter. If the disallowance is based on a finding by CMS of an impermissible provider donation related to payments under this subchapter, HHSC proposes that the governmental entity responsible for the non-federal share of the payments must transfer to HHSC the amount of the disallowance. HHSC proposes this approach 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. HHSC is particularly interested in receiving comments on this provision of the proposed rule.

If CMS disallows federal funds related to payments under this subchapter on grounds other than provider donations, HHSC proposes relying on other federal and state law and contract authority to recoup from MCOs, providers, or governmental entities.

The recoupment provision describes circumstances other than disallowances under which HHSC may recoup from MCOs or MCOs may recoup from providers, or under which adjustments to payments may be made.

The state's cost of administering programs provision indicates that, to the extent authorized under state and federal law, HHSC will collect the state's cost of administering a program authorized under Subchapter O from participants in the program generating the costs.

SECTION-BY-SECTION SUMMARY

Proposed new §353.1301(a) describes the purpose of this subchapter.

Proposed new §353.1301(b) defines key terms used in the subchapter.

Proposed new §353.1301(c) details that CMS approval is necessary prior to implementation of any directed payment program.

Proposed new §353.1301(d) states that other sections within the subchapter describe program specific requirements.

Proposed new §353.1301(e) describes the different sources of the non-federal share of these Medicaid payments.

Proposed new §353.1301(f) states that each program will detail its own requirements surrounding the transfer of the non-federal share of the Medicaid payments.

Proposed new §353.1301(g) describes the reconciliation process for IGT.

Proposed new §353.1301(h) describes the consequences for a governmental entity not transferring the non-federal share of a Medicaid payment.

Proposed new §353.1301(i) describes the consequences for an MCO not complying with a contract provision described in this subchapter.

Proposed new §353.1301(j) describes the methods by which payments will be recouped and the procedure in the event of a disallowance.

Proposed new §353.1301(k) describes circumstances under which HHSC or an MCO may recoup overpayments or payments made in error or as the result of fraud.

Proposed new §353.1301(l) indicates that, to the extent authorized under state and federal law, HHSC will collect the state's cost of administering a program authorized under Subchapter O from participants in the program generating the costs.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for the each year of the first five years the proposed rule is in effect, there will be no fiscal impact to state government or local governments as a result of this rule. This rule sets out the general requirements for directed payment models but does not create any such model.

PUBLIC BENEFIT AND COST

Pam McDonald, Director of Rate Analysis, has determined that for each year of the first five years the rule is in effect, the anticipated public benefit of adopting the proposed rule is the understanding of basic elements applicable to all directed payment programs.

Ms. McDonald has also determined that there are no probable economic costs to persons required to comply with the proposed rule.

HHSC has determined that the proposed rule will not affect a local economy. There is no anticipated negative impact on local employment.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

HHSC has determined that there will be no adverse economic effect on small businesses or micro-businesses to comply with the proposed rule. The implementation of the proposed rule does not require any changes in practice or any additional cost.

REGULATORY ANALYSIS

HHSC has determined that this proposal is not a "major environmental rule" as defined by §2001.0225 of the Texas Government Code. A "major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under §2007.043 of the Government Code.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Monica Leo, Staff Counsel, Brown Heatly Building, MC: 1100, 4900 North Lamar Blvd, Austin, TX 78714-9030; by fax to (512) 424-6586; or by e-mail to Monica.Leo@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

PUBLIC HEARING

A public hearing is scheduled for February 1, 2017, from 2:00 p.m. to 4:15 p.m. (Central Time) in the Public Hearing Room, Brown Heatly Building, 4900 North Lamar Blvd, Austin, TX 78714-9030. Persons requiring further information, special assistance, or accommodations should contact Amy Chandler at (512) 487-3419.

STATUTORY AUTHORITY

The new rule is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with board 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.

The proposed new rule implements Texas Human Resources Code, Chapter 32, and Texas Government Code, Chapter 531; and Texas Government Code Chapter 533. No other statutes, articles, or codes are affected by this proposal.

§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, investments, and 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 from non-state governmental entities. No state general revenue 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. Providers operated by the governmental entity are ineligible for future participation in programs under this subchapter.

(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 may also 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.

(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 proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 9, 2017.

TRD-201700102
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: February 19, 2017
For further information, please call: (512) 424-6900

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1 TAC §353.1303

The Texas Health and Human Services Commission (HHSC) proposes new Subchapter O, Delivery System and Provider Payment Initiatives, §353.1303, concerning Quality Incentive Payment Program for Nursing Facilities.

Elsewhere in this issue, related §353.1301 of this title (relating to General Provisions) is proposed concurrent with this section and describes general provisions that apply to this and other sections under this new Subchapter O.

Background and Justification

This proposed 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 its 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).

In 2014, HHSC established the Minimum Payment Amount Program (MPAP). The MPAP, which became effective March 1, 2015, established minimum payment amounts for qualified NFs participating in STAR+PLUS. The STAR+PLUS managed care organizations (MCOs) paid the minimum payment amounts to qualified NFs based on state direction. The MPAP was always intended to be a short-term program that would ultimately transition to a performance-based initiative.

The goal of transition was reinforced during the 84th Legislative Session. The General Appropriations Act for the 2016 - 2017 biennium contains HHSC Budget Rider 97, which directs HHSC to transition the MPAP to QIPP.

Conceptual Framework