(C) Quarterly payments from Component Three associated with each quality metric will be equal to the total value of Component Three associated with the quality metric divided by four.

(D) For purposes of the calculations described in subparagraphs (B) and (C) of this paragraph, each metric will be allocated an equal portion of the total dollars included in the component.

(2) MCOs will distribute payments to enrolled NFs as they meet their reporting and quality metric requirements. Payments will be equal to the portion of the QIPP PMPM associated with the achievement for the time period in question multiplied by the number of member months for which the MCO received the QIPP PMPM.

(i) Performance requirements.

(1) Quality metrics.

(A) There will be a minimum of three quality metrics for an eligibility period.

(B) Quality metrics may change from eligibility period to eligibility period. Information regarding specific quality metrics for an eligibility period will be provided annually through the QIPP webpage on the HHSC website on or before February 1 of the calendar year that also contains the first month of the eligibility period.

(C) Quality metric baselines will be based on each individual NF's average performance on the metric as reported by CMS for the federal quarter that ends prior to the first day of the eligibility period and the three prior federal quarters, or as determined by HHSC.

(D) Quality metric benchmarks will be based on the national average for the metric as reported by CMS for the federal quarter that ends prior to the first day of the eligibility period, or as determined by HHSC.

(2) Achievement requirements. In order to receive payments from Components Two and Three for a quality metric, a NF must show improvement over the baseline or exceed the benchmark for the metric.

(A) To qualify for a payment from Component Two, a NF must meet at least the initial quarterly goal of 1.7 percent improvement from the baseline, with subsequent quarterly goals increasing to a maximum of seven percent by the end of the eligibility period. For example, to qualify for a payment from Component Two for a quality metric for the second quarter of the eligibility period, the NF must meet at least the second quarter goal of 3.4 percent improvement from the baseline.

(B) To qualify for a payment from Component Three, a NF must meet at least the initial quarterly goal of 5.0 percent improvement from the baseline with subsequent quarterly goals increasing to a maximum of 20 percent by the end of the eligibility period. For example, to qualify for a payment from Component Three for a quality metric for the second quarter of the eligibility period, the NF must meet at least the second quarter goal of 10.0 percent improvement from the baseline. A NF that qualifies for a payment from Component Three for a metric automatically qualifies for a payment from Component Two for the same metric.

(C) A NF that exceeds the benchmark for a metric qualifies for a payment from both Component Two and Component Three for that metric. A NF that exceeds the benchmark may decline in performance and still qualify for a payment from both Component Two and Component Three as long as the NF continues to exceed the benchmark for the metric.

(j) Changes of ownership.

(1) If an enrolled NF changes ownership during the eligibility period to private ownership, the NF under the new ownership must meet the private NF eligibility requirements described in this section in order to continue QIPP participation during the eligibility period.

(2) If a non-state government-owned NF changes ownership during the eligibility period to another non-state governmental entity, the NF under the new ownership must meet the non-state government-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 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.

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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 §353.1305

The Texas Health and Human Services Commission (HHSC) proposes new Subchapter O, Delivery System and Provider Payment Initiatives, §353.1305, concerning Regional Uniform Rate Increases for Hospital Services.

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

The proposed new section 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. This section 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 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 proposed 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.

*Eligibility*

HHSC determines eligibility for rate increases by SDA and class of hospital. The SDA must have at least one governmental entity willing to provide IGT to support the rate increase. Also, to be eligible for the rate increase, a hospital must be within a class designated by HHSC to receive the increase.

HHSC proposes classifying hospitals into seven groups: state-owned hospitals, children's hospitals, non-urban public hospitals, rural hospitals, urban public hospitals, institutions for mental diseases, and all other hospitals. The classifications allow HHSC to direct rate increases where they are most needed to bring reimbursement closer to cost for all hospitals in the participating SDA. The percentage rate increase will be uniform for all hospitals within each class; but if HHSC directs rate increases to more than one class within an SDA, the percentage rate increase may vary between classes.

*Services subject to rate increase*

HHSC may direct rate increases for all or a subset of inpatient hospital services; all or a subset of outpatient hospital services; or all or a subset of both types of services, based on advancing the goals and objectives of HHSC's quality strategy.

*Determination of rate increase*

HHSC will consider several factors in determining the percentage rate increase that will be directed for one or more classes of hospital within an SDA, including the amount of available funding; the class or classes of hospital eligible to receive the increase; the type of service subject to the rate increase; the actuarial soundness of the capitation payment needed to support the rate increase; available budget neutrality room under any applicable federal waiver programs; and other HHSC goals and priorities.

*Reconciliation and recoupment*

HHSC will follow the methodology described in §353.1301 of this subchapter (proposed concurrent with this §353.1305) to reconcile the amount of non-federal funds expended under this section and to authorize recoupments of overpayment or disallowance amounts.

SECTION-BY-SECTION SUMMARY

Proposed new §353.1305(a) describes the circumstances under which HHSC will direct a uniform percentage rate increase.

Proposed new §353.1305(b) defines key terms used in the section.

Proposed new §353.1305(c) describes the classes of hospital eligible for rate increases.

Proposed new §353.1305(d) describes the eligibility criteria for receiving the rate increase.

Proposed new §353.1305(e) describes the basis for identifying hospital services subject to the rate increase.

Proposed new §353.1305(f) describes the methodology for determining the percentage of rate increase.

Proposed new §353.1305(g) describes when sponsoring governmental entities must transfer funds to HHSC to support the rate increases and the amount of funds that must be transferred.

Proposed new §353.1305(h) describes the effective date of rate increases.

Proposed new §353.1305(i) refers to §353.1301(g) for the description of the reconciliation process.

Proposed new §353.1305(j) refers to §353.1301(k) for the description of the recoupment authority.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years the proposed rule is in effect, there may be a fiscal impact to state government for rate increases to state-owned hospitals, but there is insufficient information to provide an estimate at this time because HHSC does not know what state-owned hospitals or state agencies will choose to sponsor rate increases under this section or at what level of funding. There will be no fiscal impact to state government for rate increases to non-state-owned hospitals because the non-federal share of the increase in capitation payments will be funded with IGTs from non-state governmental entities. There may be a fiscal impact to local governments, but there is insufficient information to provide an estimate because HHSC does not know which non-state governmental entities will choose to sponsor rate increases under this section or at what level of funding.

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. Hospitals eligible for the rate increases will not be required to alter their business practices and will receive higher reimbursement for providing the same services.

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 public

will benefit from the adoption of the rule. The anticipated public benefit will be enhanced care coordination and better health outcomes as a result of flowing funding through the managed care organizations.

Ms. McDonald has also determined that there are no probable economic costs to persons who are 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.

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 3:00 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 broad rulemaking authority, and 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; and with Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The proposed rule implements Texas Human Resources Code, Chapter 32; Texas Government Code, Chapter 531; and Texas Government Code Chapter 533.

*§353.1305. Regional Uniform Rate Increases for Hospital Services.*

(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 (9) 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 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.

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

(9) 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 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 hospitals;

(D) state-owned hospitals;

(E) urban public hospitals;

(F) institutions for mental diseases; and

(G) all other hospitals.

(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; 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 sponsoring governmental entities on one or both of the following:

*(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 sponsoring governmental entities 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; and

(F) other HHSC goals and priorities.

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

(g) Timing and amount of transfer of non-federal share.

(1) Sponsoring governmental entities must complete the IGT for the first six months of the program period no later than May 1 of the calendar year that also contains the first month of the program period, unless otherwise instructed by HHSC.

(2) Following the transfer of funds described in paragraph (1) 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.

(3) 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 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.

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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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# TITLE 19. EDUCATION

## PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD