TO: Medical Care Advisory Committee

DATE: August 12, 2021

FROM: Victoria Grady, Director
Provider Finance

SUBJECT: Hospital Augmented Reimbursement Program

Agenda Item No.: 10

New: §355.8070, Hospital Augemented Reimbursement Program

BACKGROUND: ☐ Federal Requirement ☐ Legislative Requirement ☒ Other: (e.g., Program Initiative)

The Texas Health and Human Services Commission (HHSC) proposes a new rule §355.8070, concerning the Hospital Augmented Reimbursement Program. The program will provide additional hospital funding to help offset Medicaid costs. The initial program design will be limited to publicly-owned and publicly-operated hospitals and to private hospitals, with other types of hospitals added in subsequent time periods. The payment calculation will be based on the individual participating hospital's Medicare payment gap and/or Average Commercial Reimbursement (ACR) gap. The hospital's maximum payment before any reductions will be the maximum of the Medicare payment gap and ACR gap for hospitals that submit ACR data and Medicare gap for those that did not submit ACR data. This total will be capped at the total aggregate Medicare Upper Payment Limit (UPL) gap for hospital services. The most current Medicare UPL demonstration available at the time of calculation will be used.

ISSUES AND ALTERNATIVES:

There are no concerns related to this proposed rule. The program will provide additional funding to hospitals to help offset Medicaid costs.

STAKEHOLDER INVOLVEMENT:

HHSC Provider Finance held several workgroup meetings with stakeholders to discuss plans for the proposed program.

FISCAL IMPACT:

☒ None

RULE DEVELOPMENT SCHEDULE:

July 2021	Publish proposed rules in *Texas Register*
August 5, 2021	Present to Hospital Payment Advisory Committee
August 12, 2021	Present to the Medical Care Advisory Committee
August 19, 2021	Present to HHSC Executive Council
September 2021	Publish adopted rules in *Texas Register*
September 2021	Effective date

REQUESTED ACTION: ***(Check appropriate box)***

☐ The MCAC recommends approval of the proposed rules for publication.

☒ Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355 REIMBURSEMENT RATES
SUBCHAPTER J PURCHASED HEALTH SERVICES
DIVISION 4 MEDICAID HOSPITAL SERVICES

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes new §355.8070, concerning the Hospital Augmented Reimbursement Program, for program periods on or after October 1, 2021.

BACKGROUND AND PURPOSE

HHSC plans to create this program to continue the financial transition for providers who have historically participated in the Delivery System Reform Incentive Payment program. We continue to work on solutions to preserve the financial resources many of our hospitals depend on to provide access to quality care to Medicaid clients and the uninsured. The Hospital Augmented Reimbursement Program would be created, subject to approval by the Centers for Medicare and Medicaid Services (CMS), through the Medicaid state plan. State plan programs and services do not impact 1115 Waiver budget neutrality. HHSC intends to submit state plan amendments to CMS to request authorization to make payments as described under new §355.8070 to non-state government-owned and -operated hospitals and to private hospitals. State plan amendments to include various hospital ownership types may be submitted on individual timelines. State plan amendment submission timelines will be determined outside of the rulemaking process in accordance with the state plan amendment administrative processes. The program will provide additional funding to hospitals to help offset the cost hospitals incur while providing Medicaid services.

The payment calculation will be based on a participating hospital's Medicare payment gap and/or Average Commercial Reimbursement (ACR) gap. The hospital's maximum payment before any reductions will be the combined Medicare payment gap and ACR gap for hospitals that submitted ACR data and the Medicare gap for those that did not submit ACR data. Payments will be capped at the total aggregate Medicare Upper Payment Limit (UPL) gap for all hospital services. The most current Medicare UPL demonstration available at the time of calculation will be used.

SECTION-BY-SECTION SUMMARY

Proposed new §355.8070(a) describes the purpose and goals of the program. Subsection (b) defines key terms used in the section. Subsection (c) describes participation requirements. Subsection (d) describes payments for non-state government-owned and operated hospitals, including eligibility requirements, the non-federal share of program payments, and describes the payment calculation and methodology. Subsection (e) describes payments for private hospitals including the requirements for participation, eligibility requirements, the non-federal share of

program payments, and describes the payment calculation and methodology. Subsection (f) describes payments for state-owned hospitals including the requirements for participation, eligibility requirements, the non-federal share of program payments, and describes the payment calculation and methodology. Subsection (g) describes payments for state government-owned Institutions for Mental Diseases including the requirements for participation, eligibility requirements, the non-federal share of program payments, and describes the payment calculation and methodology. Subsection (h) describes the payments for state private Institutions for Mental Diseases, including the requirements for participation, eligibility requirements, and the non-federal share of program payments, and describes the payment calculation and methodology. Subsection (i) describes requirements in the case of changes in operation. Subsection (j) discusses the reconciliation of the amount of the non-federal funds actually expended. Subsection (k) describes the frequency of the payments.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, there will not be a fiscal impact on state government as a result of enforcing and administering the rule. The non-federal share of the Medicaid payments is provided by local governmental entities through intergovernmental transfers (IGTs) to HHSC. HHSC will then draw down federal matching funds to issue the program payments.

There is a possibility of fiscal implications to local governmental entities, but participation in the Hospital Augmented Reimbursement Program is voluntary. The non-federal share of the supplemental payments is provided by local governmental entities through intergovernmental transfers. A fiscal impact to these local governmental entities may occur only if the local governmental entity chooses to provide the IGT to support payments to eligible hospitals.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rule will be in effect:

(1) the proposed rule will create a government program;

(2) implementation of the proposed rule will not affect the number of HHSC employee positions;

(3) implementation of the proposed rule will result in no assumed change in future legislative appropriations;

(4) the proposed rule will not affect fees paid to HHSC;

(5) the proposed rule will create a new rule;

(6) the proposed rule will not expand, limit, or repeal existing rules;

(7) the proposed rule will increase the number of individuals subject to the rule; and

(8) HHSC has insufficient information to determine the proposed rule's effect on the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood, Chief Financial Officer, has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities required to comply with the rule as proposed. Participation in the program is voluntary and places no burden on small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public will benefit from adoption of the rule. The public benefit anticipated from enforcing or administering the rule is the additional funding provided to participating hospitals to help them offset Medicaid costs.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the 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 Texas Government Code §2007.043.

PUBLIC HEARING

A public hearing to receive comments on the proposal will be held by HHSC through a webinar. The meeting date and time will be posted on the HHSC Communications and Events Website at https://hhs.texas.gov/about-hhs/communications-events and the HHSC Provider Finance Hospitals website at https://rad.hhs.texas.gov/provider-finance-communications.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Laura Skaggs in the HHSC Provider Finance for Hospitals department at PFD_Hospitals@hhsc.state.tx.us.

Written comments on the proposal may be submitted to the HHSC Provider Finance Department, 4900 North Lamar Blvd., Austin, TX 78751 (Mail Code H-400); P.O. Box 149030, Austin, TX 78714-9030 (Mail Code H-400); by fax to (512)-730-7475; or by email to PFD_Hospitals@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 21 days after the date of this issue of the *Texas Register*. Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When faxing or emailing comments, please indicate "Comments on Proposed Rule 21R108" in the subject line.

STATUTORY AUTHORITY

New §355.8070 is proposed under Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; 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 Texas Government Code §531.021(b-1), 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.

The new rule affects Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 462-6239.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language (No change.) = No changes are being considered for the designated subdivision

TITLE 1	ADMINISTRATION
PART 15	TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 355	REIMBURSEMENT RATES
SUBCHAPTER J	PURCHASED HEALTH SERVICES
DIVISION 4	MEDICAID HOSPITAL SERVICES

§355.8070. Hospital Augmented Reimbursement Program.

(a) Introduction. This section establishes the Hospital Augmented Reimbursement (HARP) Program, wherein the Texas Health and Human Services Commission (HHSC) directs payments to eligible non-state government owned hospitals, private hospitals, state-owned hospitals, state government-owned Institutions for Mental Diseases (IMDs), and private IMDs. This section also describes the methodology used by HHSC to calculate and administer such payments. A provider is eligible for a payment under this section only if HHSC has submitted and CMS has approved a state plan amendment permitting HHSC to make payments under this section to the hospital class to which the provider belongs.

(b) Definitions. The following definitions apply when the terms are used in this section.

(1) Average Commercial Reimbursement (ACR) gap--The difference between what an average commercial payor is estimated to pay for the services and what Medicaid paid for the same services.

(2) Fee-for-Service (FFS)--A system of the health insurance payment in which a health care provider is paid a fee by HHSC through the contracted Medicaid claims administrator directly, for each service rendered. For Texas Medicaid purposes, fee-for-service excludes any service rendered under a managed care program through a managed care organization.

(3) 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 services furnished in a skilled nursing facility, intermediate care facility services furnished by a hospital with swing-bed approval, or any other services that HHSC determines should not be subject to payment.

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

(5) Medicare payment gap--The difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services.

(6) Non-state government-owned and operated hospital--A hospital that is owned and operated by a local government entity, including but not limited to a city, county, or hospital district.

(7) 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.

(8) Private hospital--Any hospital that is not government-owned and operated.

(9) Private Institution for Mental Diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment or care of individuals with mental illness and that is not government-owned and operated.

(10) Program period--Each program period is equal to a federal fiscal year beginning October 1 and ending September 30 of the following year.

(11) Prospective Payment System--A method of reimbursement in which payment is made based on a predetermined, fixed amount.

(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.

(13) State government-owned hospital--Any hospital owned by the state of Texas that is not considered an IMD.

(14) State government-owned IMD--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment or care of individuals with mental illness and that is owned by the state of Texas that is considered an IMD.

(c) Participation requirements. As a condition of participation, all hospitals participating in the program must allow for the following.

(1) The hospital must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 15 business days, and the final date of the enrollment period will be at least nine days prior to the intergovernmental transfer (IGT) notification.

(A) In the application, the hospital must decide whether it will submit certain necessary data to calculate the ACR gap. If the hospital does not submit ACR data, the maximum possible program payment will be the Medicare payment gap.

(B) A hospital is required to maintain all supporting documentation at the hospital for any information provided under subparagraph (A) of this paragraph for a period of no less than five years.

(2) If a provider has changed ownership in the past five years in a way that impacts eligibility for this program, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, this program.

(d) Payments for non-state government-owned and operated hospitals.

(1) Eligible hospitals. Payments under this subsection will be limited to hospitals defined as "non-state government owned and operated hospital" that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

(2) Non-federal share of program payments. The non-federal share of the payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the program.

(A) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(B) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC's website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Inpatient Payment Methodology.

(A) HHSC will calculate for each participating hospital the inpatient Medicare payment gap.

(B) If the hospital also submitted ACR data, HHSC will calculate an inpatient ACR gap.

(C) The hospital's maximum inpatient payment before any reductions will be the maximum of subparagraph (A) and subparagraph (B) of this paragraph for hospitals that submit ACR data and subparagraph (A) of this paragraph for those that did not submit ACR data.

(D) The total maximum payment from subparagraph (C) of this paragraph for all participating non-state government-owned and operated hospitals will be totaled.

(E) The total from subparagraph (D) of this paragraph will be capped at the total aggregate inpatient Medicare Upper Payment Limit (UPL) gap for all non-state government-owned and operated hospitals as defined in subsection (b) of this section. The most current Medicare UPL demonstration available at the time of calculation will be used.

(F) Divide the sum of the Medicare payment gap in subparagraph (E) of this paragraph by the number calculated in subparagraph (D) of this paragraph. This is the inpatient reduction percentage used for capping.

(G) Multiply each hospital's maximum inpatient payment before reductions from subparagraph (C) of this paragraph by the percentage calculated in subparagraph (F) of this paragraph.

(4) Outpatient Payment Methodology.

(A) HHSC will calculate for each participating hospital the outpatient Medicare payment gap.

(B) If the hospital also submitted ACR data, HHSC will calculate an outpatient ACR gap.

(C) The hospital's maximum outpatient payment before any reductions will be the maximum of subparagraph (A) and subparagraph (B) of this paragraph for hospitals that submit ACR data and subparagraph (A) of this paragraph for those that did not submit ACR data.

(D) The total maximum payment from subparagraph (C) of this paragraph for all participating non-state government-owned and operated hospitals will be totaled.

(E) The total from subparagraph (D) of this paragraph will be capped at the total aggregate outpatient UPL gap for all non-state government-owned and operated hospitals. The most current Medicare UPL demonstration available at the time of calculation will be used.

(F) Divide the sum of the Medicare payment gap in subparagraph (E) of this paragraph by the number calculated in subparagraph (D) of this paragraph. This is the outpatient reduction percentage used for capping.

(G) Multiply each hospital's maximum outpatient payment before reductions from subparagraph (C) of this paragraph by the percentage calculated in subparagraph (F) of this paragraph.

(5) Total maximum payment per non-state government-owned and operated hospital. Calculate each hospital's maximum total payment by summing the inpatient total calculated in paragraph (3)(G) of this subsection and the outpatient total payment calculated in paragraph (4)(G) of this subsection.

(e) Payments for private hospitals.

(1) Eligible hospitals. Payments under this subsection will be limited to hospitals defined as "private hospital" in subsection (b) of this section that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

(2) Non-federal share of program payments. The non-federal share of the payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the program.

(A) HHSC must receive the non-federal portion of reimbursement for HARP through a method approved by HHSC and Centers for Medicare & Medicaid Services (CMS) for reimbursement through this program.

(B) A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a hospital's payment amount calculated in any paragraph under this subchapter, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal share actually transferred.

(C) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(D) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC's website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Inpatient Payment Methodology.

(A) HHSC will calculate for each participating hospital the inpatient Medicare payment gap.

(B) If the hospital also submitted ACR data, HHSC will calculate an inpatient ACR gap.

(C) The hospital's maximum inpatient payment before any reductions will be the maximum of subparagraph (A) and subparagraph (B) of this paragraph for hospitals that submit ACR data and subparagraph (A) of this paragraph for those that did not submit ACR data.

(D) The total maximum payment from subparagraph (C) of this paragraph for all participating private hospitals will be totaled.

(E) The total from subparagraph (D) of this paragraph will be capped at the total aggregate inpatient Medicare UPL gap for all private hospitals. The most current Medicare UPL demonstration available at the time of calculation will be used.

(F) Divide the sum of the Medicare payment gap in subparagraph (E) of this paragraph by the number calculated in subparagraph (D) of this paragraph. This is the inpatient reduction percentage used for capping.

(G) Multiply each hospital's maximum inpatient payment before reductions from subparagraph (C) of this paragraph by the percentage calculated in subparagraph (F) of this paragraph.

(4) Outpatient Payment Methodology.

(A) HHSC will calculate for each participating hospital the outpatient Medicare payment gap.

(B) If the hospital also submitted ACR data, HHSC will calculate an outpatient ACR gap.

(C) The hospital's maximum outpatient payment before any reductions will be the maximum of subparagraph (A) and subparagraph (B) of this paragraph for hospitals that submit ACR data and subparagraph (A) of this paragraph for those that did not submit ACR data.

(D) The total maximum payment from subparagraph (C) of this paragraph for all participating private hospitals will be totaled.

(E) The total from subparagraph (D) of this paragraph will be capped at the total aggregate outpatient Medicare UPL gap for all private hospitals. The most current Medicare UPL demonstration available at the time of calculation will be used.

(F) Divide the sum of the Medicare payment gap in subparagraph (E) of this paragraph by the number calculated in subparagraph (D) of this paragraph. This is the outpatient reduction percentage used for capping.

(G) Multiply each hospital's maximum outpatient payment before reductions from subparagraph (C) of this paragraph by the percentage calculated in subparagraph (F) of this paragraph.

(5) Total maximum payment per private hospital. Calculate the maximum total payment by summing the inpatient total calculated in paragraph (3)(G) of this subsection and the outpatient total payment calculated in paragraph (4)(G) of this subsection.

(f) Payments for state government-owned hospitals.

(1) Eligible hospitals. Payments under this subsection will be limited to hospitals defined as "state government-owned hospital" in subsection (b) of this section that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

(2) Non-federal share of program payments. The non-federal share of the payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the program.

(A) HHSC must receive the non-federal portion of reimbursement for HARP through a method approved by HHSC and CMS for reimbursement through this program.

(B) A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a hospital's payment amount calculated in any paragraph under this subchapter, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal share actually transferred.

(C) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(D) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC will publish the IGT deadlines and all associated dates on its Internet website.

(3) Inpatient Payment Methodology

(A) HHSC will calculate the inpatient Medicare payment gap for each state government-owned participating hospital reimbursed through the Prospective Payment System (PPS).

(B) If the hospital also submitted ACR data, HHSC will calculate an inpatient ACR gap.

(C) The hospital's maximum inpatient payment before any reductions will be the maximum of subparagraph (A) and subparagraph (B) of this paragraph for hospitals that submit ACR data and subparagraph (A) of this paragraph for those that did not submit ACR data.

(D) The total maximum payment from subparagraph (C) of this paragraph for all participating state government-owned hospitals will be totaled.

(E) The total from subparagraph (D) of this paragraph will be capped at the total aggregate inpatient Medicare Upper Payment Limit (UPL) gap for all state government-owned hospitals. The most current Medicare UPL demonstration available at the time of calculation will be used.

(F) Divide the sum of the Medicare payment gap in subparagraph (E) of this paragraph by the number calculated in subparagraph (D) of this paragraph. This is the inpatient reduction percentage used for capping.

(G) Multiply each hospital's maximum inpatient payment before reductions from subparagraph (C) of this paragraph by the percentage calculated in subparagraph (F) of this paragraph.

(4) Outpatient Payment Methodology.

(A) HHSC will calculate for each participating hospital the outpatient Medicare payment gap.

(B) If the hospital also submitted ACR data, HHSC will calculate an outpatient ACR gap.

(C) The hospital's maximum outpatient payment before any reductions will be the maximum of subparagraph (A) and subparagraph (B) of this paragraph for hospitals that submit ACR data and subparagraph (A) of this paragraph for those that did not submit ACR data.

(D) The total maximum payment from subparagraph (C) of this paragraph for all participating state government-owned hospitals will be totaled.

(E) The total from subparagraph (D) of this paragraph will be capped at the total aggregate outpatient Medicare Upper Payment Limit (UPL) gap for all state

government-owned. The most current Medicare UPL demonstration available at the time of calculation will be used.

(F) Divide the sum of the Medicare payment gap in subparagraph (E) of this paragraph by the number calculated in subparagraph (D) of this paragraph. This is the outpatient reduction percentage used for capping.

(G) Multiply each hospital's maximum outpatient payment before reductions from subparagraph (C) of this paragraph by the percentage calculated in subparagraph (F) of this paragraph.

(5) Total maximum payment per state government-owned hospitals. Calculate each hospital's maximum total payment by summing the inpatient total calculated in paragraph (3)(G) of this subsection and the outpatient total payment calculated in paragraph (4)(G) of this subsection.

(g) Payments for state government-owned IMDs.

(1) Eligible hospitals.

(A) Payments under this subsection will be limited to hospitals defined as "state government-owned IMD" in subsection (b) of this section that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

(B) The hospital must have submitted at least one adjudicated FFS Medicaid claim for each reporting period to be eligible for payment.

(2) Non-federal share of program payments. The non-federal share of the payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the program.

(A) HHSC must receive the non-federal portion of reimbursement for HARP through a method approved by HHSC and CMS for reimbursement through this program.

(B) A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a hospital's payment amount calculated in any paragraph under this subchapter, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal share actually transferred.

(C) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the

program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(D) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC's website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Inpatient Payment Methodology.

(A) HHSC will calculate the inpatient Medicare payment gap for each state government-owned IMD participating hospital.

(B) If the hospital also submitted ACR data, HHSC will calculate an inpatient ACR gap.

(C) The hospital’s maximum inpatient payment before any reductions will be the maximum of subparagraph (A) and subparagraph (B) of this paragraph for hospitals that submit ACR data and subparagraph (A) of this paragraph for those that did not submit ACR data.

(D) The total maximum payment from subparagraph (C) of this paragraph for all participating state government-owned IMD hospitals will be totaled.

(E) The total from subparagraph (D) of this paragraph will be capped at the total aggregate inpatient Medicare UPL gap for all state government-owned IMD. The most current Medicare UPL demonstration available at the time of calculation will be used.

(F) Divide the sum of the Medicare payment gap in subparagraph (E) of this paragraph by the number calculated in subparagraph (D) of this paragraph. This is the inpatient reduction percentage used for capping.

(G) Multiply each hospital’s maximum inpatient payment before reductions from subparagraph (C) of this paragraph by the percentage calculated in subparagraph (F) of this paragraph.

(4) The total maximum payment per state government-owned IMD is the inpatient maximum total payment calculated in paragraph (3)(G) of this subsection.

(h) Payments for private IMDs.

(1) Eligible hospitals.

(A) Payments under this subsection will be limited to hospitals defined as "private IMD" in subsection (b) of this section that participate in Texas Medicaid fee-for-service.

(B) The hospital must have submitted at least one adjudicated FFS Medicaid claim for each reporting period to be eligible for payment.

(2) Non-federal share of program payments. The non-federal share of the payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the program.

(A) HHSC must receive the non-federal portion of reimbursement for HARP through a method approved by HHSC and CMS for reimbursement through this program.

(B) A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a hospital's payment amount calculated in any paragraph under this subchapter, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal share actually transferred.

(C) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(D) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC's website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Inpatient Payment Methodology.

(A) HHSC will calculate the inpatient Medicare payment gap for each private IMD participating hospital.

(B) If the hospital also submitted ACR data, HHSC will calculate an inpatient ACR gap.

(C) The hospital's maximum inpatient payment before any reductions will be the maximum of subparagraph (A) and subparagraph (B) of this paragraph for

hospitals that submit ACR data and subparagraph (A) of this paragraph for those that did not submit ACR data.

(D) The total maximum payment from subparagraph (C) of this paragraph for all participating private IMD hospitals will be totaled.

(E) The total from subparagraph (D) of this paragraph will be capped at the total aggregate inpatient Medicare UPL gap for all private IMD. The most current Medicare UPL demonstration available at the time of calculation will be used.

(F) Divide the sum of the Medicare payment gap in subparagraph (E) of this paragraph by the number calculated in subparagraph (D) of this paragraph. This is the inpatient reduction percentage used for capping.

(G) Multiply each hospital's maximum inpatient payment before reductions from subparagraph (C) of this paragraph by the percentage calculated in subparagraph (F) of this paragraph.

(4) The total maximum payment per private IMD is the inpatient maximum total payment calculated in paragraph (3)(G) of this subsection.

(i) Changes in operation. If an enrolled hospital closes voluntarily or ceases to provide hospital services in its facility, the hospital must notify the HHSC Provider Finance Department by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide hospital services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

(j) 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. If the amount of non-federal funds actually expended under this section is less than the amount transferred to HHSC, HHSC will refund the balance proportionally to how it was received.

(k) Payments under this section will be made on a semi-annual basis.