TO: Medical Care Advisory Committee

DATE: February 11, 2021

FROM: Victoria Grady, Director of Provider Finance

SUBJECT: Uniform Hospital Rate Increase Program Reforms

Agenda Item No.: 15

Amendment to: §353.1305, Uniform Hospital Rate Increase Program

New Rules: §353.1306, Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021; and §353.1307 Quality Metrics and Required Reporting Used to Evaluate the Success of the Comprehensive Hospital Increase Reimbursement Program.

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

The Texas Health and Human Services Commission (HHSC) proposes to amend §353.1305, relating to Uniform Hospital Rate Increase Program; proposes new §353.1306, relating to Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021; and proposes new §353.1307, relating to Quality Metrics and Required Reporting Used to Evaluate the Success of the Comprehensive Hospital Increase Reimbursement Program, in Texas Administrative Code (TAC) Title 1, Part 15, Chapter 353, Subchapter O.

In order to continue incentivizing hospitals to improve access, quality, and innovation in the provision of hospital services in Year 5 of the program (i.e., September 1, 2021, through August 31, 2022) and beyond, HHSC is proposing new quality metrics, eligibility requirements, and financing components for the program. HHSC is also proposing these amendments to comply with federal regulations that require directed-payment programs to advance goals included in the state's managed care quality strategy and to align with the ongoing efforts to transition from the Delivery System Reform Incentive Payment program.

During the months of September and October 2020, HHSC convened a workgroup of stakeholders including hospitals from all hospital classes, such as children's, rural, urban, publicly-owned, privately-owned, state-owned, and advocacy groups representing hospitals to assist in the design of the proposed program structure.

The Uniform Hospital Rate Increase Program was initially implemented on December 1, 2017, and operated under Texas Administrative Code Title 1 §353.1301 and §353.1305 for the initial program year and subsequent years. Section 353.1301 is not being amended at this time. The amendment to §353.1305

will make the rule applicable to the program before September 1, 2021.

New §353.1306 and §353.1307 will apply to the program begining on September 1, 2021, and will re-name the program the Comprehensive Hospital Increase Reimbursement Program (CHIRP), which will be comprised of the Uniform Hospital Rate Increase Payment (UHRIP) and the Average Commercial Incentive Award (ACIA). A description of the conceptual framework of the program is as follows:

Eligibility and Enrollment

CHIRP is open to six classes of hospitals: children's hospitals, rural hospitals, state-owned hospitals that are not institutions for mental diseases (IMDs), urban hospitals, non-state-owned IMDs, and state-owned IMDs. Eligibility for hospitals will now be based upon an individual hospital application, which will allow hospitals to participate even if other hospitals within the same class do not wish to participate.

Capitation Rate Structure

CHIRP dollars will be limited by 1115 waiver budget-neutrality capacity and the amount of intergovernmental transfer (IGT) funds available for the program. The non-federal share of all CHIRP payments is funded through IGTs from sponsoring governmental entities. No general revenue is available to support CHIRP. The MCOs' distribution of CHIRP funds to the enrolled hospitals will be based on the hospital's actual utilization as a uniform percentage increase. CHIRP IGTs for a specific capitation rate period will be due to HHSC approximately three months prior to the beginning of the rate period to allow HHSC's actuaries certainty as to the amount of funding to be incorporated into the capitation rates for CHIRP. The amount of the capitation will be determined by the amount of the non-federal share available for the program.

CHIRP funds will be paid through two components of the managed care per member per month (PMPM) capitation rates. Each component's value will be determined as a percentage of the amount of funding available for the CHIRP program.

Capitation Rate Components

The UHRIP Component will be equal to a percentage of the estimated difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services (Medicare gap) on a per class basis. UHRIP payments will be paid as a uniform rate increase per class and will be distributed based upon actual paid claims.

The ACIA Component will be equal to a percentage of the difference between what an average commercial payer is estimated to pay for the services and what Medicaid actually paid for the same services (ACR gap) less payments received under UHRIP. ACIA payments will be paid as a uniform rate increase per class and will be distributed based upon actual paid claims.

Quality Evaluation

For each program period, HHSC will specify the performance requirements that will

be associated with the designated quality metric that is expected to advance at least one of the goals and objectives in the quality strategy. Achievement of the performance requirements will be used to evaluate the degree to which the program advances at least one of the goals and objectives that are incentivized by the CHIRP payments.

HHSC will publish notice of the proposed metrics and their associated performance requirements no later than January 31 of the calendar year that precedes the first month of the eligibility period. Final quality metrics and performance requirements will be provided through the CHIRP webpage on HHSC's website on or before February 28 of the calendar year that also contains the first month of the eligibility period.

ISSUES AND ALTERNATIVES:

As mentioned above, HHSC convened a workgroup with external stakeholders to assist in the design of the proposed program structure. The workgroup was held over a seven-week period during the months of September and October 2020. Topics discussed in the workgroup included: payment allocation methodology, hospital class structure, application process, IGT frequency, quality goals, and potential quality focus areas for improvement and their measurement structure. Proposals were discussed for each workgroup topic. HHSC's goal was for the workgroup to reach consensus on recommendations to present to leadership. Consensus was reached on some workgroup topics but not all.

Stakeholders agreed that participation in the program should be voluntary and that an application process would allow hospitals to opt out of the program if desired. Stakeholders also agreed that the program payment methodology should be simple and produce predictable payments, while considering the percentage of hospital costs, but did not reach consensus on a proposed methodology. Throughout the workgroup, stakeholders consistently asked HHSC to consider a payment allocation methodology that results in a larger funding pool for the program and requested to preserve the structure of the current program. HHSC's conversations with Centers for Medicare and Medicaid Services have made it clear that it is unlikely for an increased pool to be approved without the state making changes to the current program. Despite this, stakeholders remained generally opposed to adding quality measures to the program and recommended HHSC create a separate program to incorporate quality.

STAKEHOLDER INVOLVEMENT:

Key stakeholders participating in the workgroup included representatives from six hospital associations: Texas Hospital Association, Teaching Hospitals of Texas, Children's Hospital Association of Texas, Texas Association of Voluntary Hospitals, Texas Organization of Rural & Community Hospital, and Texas Essential Healthcare Partnerships. The workgroup also included eight UHRIP hospital classes (Children's, Non-Urban Public, Rural Private, Rural Public, State-Owned, Urban Public, IMD, and Other).

The workgroup was broken up into two subcommittees: one focused on financing and one focused on quality. Over the seven-week period, stakeholders were encouraged to present proposals during their respective subcommittees on the

various workgroup topics. Stakeholders were also asked to provide feedback on proposals presented by HHSC. Although the proposed rules were drafted after the workgroup concluded, HHSC considered stakeholders' feedback and recommendations when drafting the rules.

The proposed rules were presented to the Hospital Payment Advisory Committee on February 4, 2021, as an informational item. The proposal will be presented to the HHSC Executive Council meeting on February 18, 2021. Additionally, HHSC held a public hearing to receive public comments following the publication of the proposed rules.

FISCAL IMPACT:

There is no anticipated fiscal impact to state government.

The proposed rules will have a fiscal impact on local governments but HHSC does not have sufficient information to determine the fiscal impact. Capitation payments for MCOs will increase in order to provide performance-based incentives for hospitals. The increase to capitation payments would be funded with federal funds and with the non-federal share provided through IGTs from governmental entities.

RULE DEVELOPMENT SCHEDULE:

January 2021	Publish proposed rules in *Texas Register*
February 4, 2021	Present to the Hospital Payment Advisory Committee
February 11, 2021	Present to the Medical Care Advisory Committee
February 18, 2021	Present to HHSC Executive Council
March 2021	Publish adopted rules in *Texas Register*
March 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 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1305, concerning Uniform Hospital Rate Increase Program; new §353.1306, concerning Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021; and new §353.1307, concerning Quality Metrics and Required Reporting Used to Evaluate the Success of the Comprehensive Hospital Increase Reimbursement Program.

BACKGROUND AND PURPOSE

To continue incentivizing hospitals to improve access, quality, and innovation in the provision of hospital services in Year 5 of the program (i.e., September 1, 2021, through August 31, 2022) and beyond, HHSC is proposing new quality metrics, eligibility requirements and financing components for the program. HHSC is also proposing these amendments to comply with federal regulations that require directed-payment programs to advance goals included in the state's managed care quality strategy and to align with the ongoing efforts to transition from the Delivery System Reform Incentive Payment program.

During the months of September and October 2020, HHSC convened a workgroup of stakeholders including hospitals from all hospital classes, such as children's, rural, urban, publicly-owned, privately-owned, state-owned, and advocacy groups representing hospitals to assist in the design of the proposed program structure.

The Uniform Hospital Rate Increase Program was initially implemented on December 1, 2017, and operated under Texas Administrative Code Title 1 §353.1301 and §353.1305 for the initial program year and subsequent years. Section 353.1301 is not being amended at this time. The amendment to §353.1305 will make the rule applicable to the program before September 1, 2021.

New §353.1306 and §353.1307 will apply to the program beginning on September 1, 2021, and will re-name the program the Comprehensive Hospital Increase Reimbursement Program (CHIRP), which will be comprised of the Uniform Hospital Rate Increase Payment (UHRIP) and the Average Commercial Incentive Award (ACIA). A description of the conceptual framework of the program is as follows:

Eligibility and Enrollment

CHIRP is open to six classes of hospitals: children's hospitals, rural hospitals, state-owned hospitals that are not institutions for mental diseases (IMDs), urban hospitals, non-state-owned IMDs, and state-owned IMDs. Eligibility for hospitals will

now be based upon an individual hospital application, which will allow hospitals to participate even if other hospitals within the same class do not wish to participate.

Capitation Rate Structure

CHIRP dollars will be limited by 1115 waiver budget-neutrality capacity and the amount of intergovernmental transfer (IGT) funds available for the program. The non-federal share of all CHIRP payments is funded through IGTs from sponsoring governmental entities. No general revenue is available to support CHIRP. The MCOs' distribution of CHIRP funds to the enrolled hospitals will be based on the hospital's actual utilization as a uniform percentage increase. CHIRP IGTs for a specific capitation rate period will be due to HHSC approximately three months prior to the beginning of the rate period to allow HHSC's actuaries certainty as to the amount of funding to be incorporated into the capitation rates for CHIRP. The amount of the capitation will be determined by the amount of the non-federal share available for the program.

CHIRP funds will be paid through two components of the managed care per member per month (PMPM) capitation rates. Each component's value will be determined as a percentage of the amount of funding available for the CHIRP program.

Capitation Rate Components

The UHRIP Component will be equal to a percentage of the estimated difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services (Medicare gap) on a per class basis. UHRIP payments will be paid as a uniform rate increase per class and will be distributed based upon actual paid claims.

The ACIA Component will be equal to a percentage of the difference between what an average commercial payer is estimated to pay for the services and what Medicaid actually paid for the same services (ACR gap) less payments received under UHRIP. ACIA payments will be paid as a uniform rate increase per class and will be distributed based upon actual paid claims.

Quality Evaluation

For each program period, HHSC will specify the performance requirements that will be associated with the designated quality metric that is expected to advance at least one of the goals and objectives in the managed care quality strategy. Achievement of the performance requirements will be used to evaluate the degree to which the program advances at least one of the goals and objectives that are incentivized by the CHIRP payments.

HHSC will publish notice of the proposed metrics and their associated performance requirements no later than January 31 of the calendar year that precedes the first month of the program period. Final quality metrics and performance requirements

will be provided on HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period.

SECTION-BY-SECTION SUMMARY

The proposed amendment of §353.1305 adds "before September 1, 2021" to the title of the section and to subsection (a) to clarify that this rule applies to UHRIP prior to September 1, 2021.

Proposed new §353.1306 provides the framework for the CHIRP for program years beginning on or after September 1, 2021. Subsection (a) describes the purpose and goals of CHIRP. CHIRP is designed to incentivize hospitals to improve access, quality and innovation in the provision of hospital services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's quality strategy. Subsection (b) defines key terms used in the section. Subsection (c) indicates the requirements for participation in the CHIRP by hospitals. Subsection (d) specifies the classes of hospitals that are authorized to be part of the CHIRP. Subsection (e) describes eligibility requirements for the CHIRP and factors HHSC will consider when identifying classes eligible for a reimbursement increase. Subsection (f) describes which services are eligible for a reimbursement increase. Subsection (g) describes the CHIRP capitation rate components and eligibility related thereto. Subsection (h) specifies the distribution of CHIRP payments. Subsection (i) describes how rate increases for eligible classes will be determined. Subsection (j) discusses the non-federal share of CHIRP payments. No general revenue funds are available for CHIRP. Subsection (k) provides the effective date of the rate increases. Subsection (l) discusses notification requirements if a provider ceases to operate. Subsection (m) discusses the reconciliation of the amount of the non-federal funds actually expended. Subsection (n) indicates the circumstances under which payments may be subject to recoupment.

Proposed new §353.1307 describes the quality metrics and required reporting used to evaluate the success of the CHIRP. Subsection (a) establishes the purpose of the section. Subsection (b) defines key terms used in the section. Subsection (c) describes the quality metrics HHSC can designate for each CHIRP capitation rate component. Possible metrics include structure or pay-for-reporting measures and will be evidence-based. Subsection (d) discusses the performance requirements that will be associated with the designated quality metrics. Achievement of performance requirements will be used to evaluate the degree to which the CHIRP advances at least one of the goals and objectives that are incentivized by the payments described in §353.1306(g) of this subchapter. Subchapter (e) provides that HHSC will publish notice of the proposed metrics and their associated performance requirements no later than January 31 preceding the first month of the program period. The notice will be published by publication on HHSC's website. Subsection (f) provides that final quality metrics and performance requirements will be provided through HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period. Subsection (g) provides that HHSC will evaluate the success of the program based on a statewide review of

reported metrics and that HHSC will publish interim evaluation findings. HHSC will publish a final evaluation report within 270 days of the conclusion of the program period.

FISCAL NOTE

Trey Wood, Chief Financial Officer for HHSC, has determined that for each year of the first five years the proposed rules are in effect, there are no foreseeable implications relating to costs or revenues of state government.

For the first five years the proposed rules are in effect, there may be financial implications to local governments. Capitation payments for MCOs will increase in order to provide performance-based incentives for hospitals. The increase to capitation payments would be funded with federal funds and with the non-federal share provided through IGTs from governmental entities.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:
(1) the proposed rules will not create or eliminate a government program;
(2) implementation of the proposed rules does not require the creation of new HHSC employee positions;
(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;
(4) the proposed rules will not affect fees paid to HHSC;
(5) the proposed rules will create a new rule;
(6) the proposed rules will limit an existing rule;
(7) the proposed rules will not change the number of individuals subject to the rules; and
(8) the proposed rules will positively affect the state’s economy.

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. There are no Texas hospitals participating in Medicaid that qualify as small businesses or micro-businesses. The proposed rules do not impose any additional fees or costs on rural communities required to comply.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules do 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 rules are in effect, the public benefit will be improved quality for Medicaid clients receiving services at participating hospitals.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the rules do not impose any additional fees or costs on those who are required to comply.

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 is scheduled for January 11, 2021, at 10:30 a.m. (Central Standard Time) to receive public comments on the proposal. Persons requiring further information, special assistance, or accommodations should email RAD_1115_Waiver_Finance@hhsc.state.tx.us.

Due to the declared state of disaster stemming from COVID-19, the hearing will be conducted online only. No physical entry to the hearing will be permitted.

Persons interested in attending may register for the public hearing at:

https://attendee.gotowebinar.com/register/8149983017350194192

After registering, a confirmation email will be sent with information about joining the webinar.

HHSC will broadcast the public hearing. The broadcast will be archived for access on demand and can be accessed at https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings.

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC, Mail Code H400, P.O. Box 13247, Austin, Texas 78711-3247, or by email to RAD_1115_Waiver_Finance@hhsc.state.tx.us.

During the current state of disaster due to COVID-19, physical forms of communication are checked with less frequency than during normal business operations. Therefore, please submit comments by email, if possible.

To be considered, comments must be submitted no later than 31 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) 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 post-marked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 21R027" in the subject line.

STATUTORY AUTHORITY

The amendment and new sections are authorized by 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; 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; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The amendment and new sections affect Human Resources Code Chapter 32 and Government Code Chapters 531 and 533.

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) 424-6637 or (512) 462-6223.

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

§353.1305. Uniform Hospital Rate Increase Program for program periods before September 1, 2021.

(a) Introduction. This section describes the circumstances for program periods before September 1, 2021, 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 (SDA) 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. An SDA 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 that is a rural hospital as defined in §355.8052 of this title (relating to Inpatient Hospital Reimbursement).

(8) Rural public hospital--A hospital that is owned and operated by a governmental entity and is a rural hospital as defined in §355.8052 of this title.

(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 an SDA 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;

(G) non-state-owned IMDs; and

(H) all other hospitals.

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

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

(1) Service delivery area. Only hospitals in an SDA 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 SDA 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.

(1) HHSC may direct the MCOs in an SDA 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.

(2) In addition to the limitations described in paragraph (1) of this subsection, rate increases for a non-state-owned IMD are limited to inpatient psychiatric hospital services provided to individuals under the age of 21 and to inpatient hospital services provided to individuals 65 years or older.

(3) UHRIP rate increases will apply only to the in-network managed care claims billed under a hospital's primary National Provider Identifier (NPI) and will not be applicable to NPIs associated with non-hospital sub-providers owned or operated by a hospital.

(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 §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 SDA to direct the percentage rate increases.

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

(1) The stakeholders in an SDA 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 SDA, 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 SDA. 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.

(k) December 2017 limited eligibility. Notwithstanding the other provisions of this section, any SDA that received approval from CMS by April 15, 2017, may participate in the program described in this section for dates of service beginning December 1, 2017. Sponsoring governmental entities must complete the IGT for the period of December 1, 2017, through February 28, 2018, by a date to be determined by HHSC.

§353.1306. Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021.

(a) Introduction. This section establishes the Comprehensive Hospital Increase Reimbursement Program (CHIRP) for program periods on or after September 1, 2021, wherein the Health and Human Services Commission (HHSC) directs a managed care organization (MCO) to provide a uniform reimbursement increase to hospitals in the MCO's network in a designated service delivery area (SDA) for the provision of inpatient services, outpatient services, or both. This section also describes the methodology used by HHSC to calculate and administer such reimbursement increases. CHIRP is designed to incentivize hospitals to improve access, quality, and innovation in the provision of hospital services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

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

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

(2) Children's hospital--A children's hospital as defined by §355.8052 of this title (relating to Inpatient Hospital Reimbursement).

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

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

(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) 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.

(7) 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. An SDA 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 (IGT) deadlines described in subsections (c) and (j) of this section.

(8) Rural hospital--A hospital that is a rural hospital as defined in §355.8052 of this title (relating to Inpatient Hospital Reimbursement).

(9) State-owned non-IMD hospital--A hospital that is owned and operated by a state university or other state agency that is not primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental disease.

(10) Urban hospital--An urban hospital as defined by §355.8052 of this title.

(c) Participation requirements. As a condition of participation, all hospitals participating in CHIRP 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 21 calendar days and the final date of the enrollment period will be at least nine days prior to the IGT notification.

(A) In the application, the hospital must select whether it will participate in optional program components described in subsection (g)(2) and (3) of this section.

(B) If the hospital chooses to participate in the optional program component described in subsection (g)(3) of this section, the hospital may be required to submit certain necessary data to calculate the ACR gap.

(C) A hospital is required to maintain all supporting documentation at the hospital for any information provided under subparagraph (B) of this paragraph for a period of no less than 5 years.

(2) The entity that owns the hospital must certify, on a form prescribed by HHSC, that no part of any payment made under the CHIRP will be used to pay a contingent fee, consulting fee, or legal fee associated with the hospitals receipt of CHIRP funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) The entity that owns the hospital must submit to HHSC, upon demand, copies of contracts it has with third parties that reference the administration of, or payments from, CHIRP.

(4) All quality metrics for which a hospital is eligible based on class, as described in subsection (d) of this section, must be reported by the participating hospital to be eligible for payment.

(d) Classes of participating hospitals.

(1) HHSC may direct the MCOs in an SDA 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) rural hospitals;

(C) state-owned non-IMD hospitals;

(D) urban public hospitals;

(E) non-state-owned IMDs; and

(F) state-owned IMDs.

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

(e) Eligibility. HHSC determines eligibility for rate increases by SDA and class of hospital.

(1) Service delivery area. Only hospitals in an SDA 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 SDA 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 managed care 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 IGTs of public funds, as indicated on the application described in subsection (c) of this section;

(C) the estimated Medicare gap for the class of hospitals, based upon the

upper payment limit demonstration most recently submitted by HHSC to the Centers for Medicare and Medicaid Services (CMS);

(D) the estimated ACR gap for the class or individual hospitals, as indicated on the application described in subsection (c) of this section; and

(E) 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 rate increase administered under this section.

(f) Services subject to rate increase.

(1) HHSC may direct the MCOs in an SDA 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 managed care quality strategy.

(2) In addition to the limitations described in paragraph (1) of this subsection, rate increases for a state-owned IMD or non-state-owned IMD are limited to inpatient psychiatric hospital services provided to individuals under the age of 21 and to inpatient hospital services provided to individuals 65 years or older.

(3) CHIRP rate increases will apply only to the in-network managed care claims billed under a hospital's primary National Provider Identifier (NPI) and will not be applicable to NPIs associated with non-hospital sub-providers owned or operated by a hospital.

(g) CHIRP capitation rate components. CHIRP funds will be paid to MCOs through two components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of CHRIP funds to the enrolled hospitals may be based on each hospital's performance related to the quality metrics as described in §353.1307 of this subchapter. The hospital must have provided at least one Medicaid service to a Medicaid client for each reporting period to be eligible for payments.

(1) In determining the percentages described under subsection (i)(1) and (2) of this section, HHSC will consider:

(A) information from the participants in the SDA (including hospitals, managed-care organizations, and sponsoring governmental entities) on 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, as indicated on the applications described in subsection (c) of this section;

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

(C) the type of service or services determined in subsection (f) 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) The Uniform Hospital Rate Increase Payment (UHRIP) is the first component.

(A) The total value of UHRIP will be equal to a percentage of the estimated Medicare gap on a per class basis.

(B) Allocation of funds across hospital classes will be proportional to each statewide hospital class's combined Medicare gap to the total Medicare gap of all hospitals.

(3) The Average Commercial Incentive Award (ACIA) is the second component.

(A) The total value of ACIA will be equal to a percentage of the ACR gap less payments received under UHRIP.

(B) Allocation of funds across hospitals will be proportional to each participating hospital's individual ACR gap to the total ACR gap for all participating hospitals.

(h) Distribution of CHIRP payments. CHIRP payments will be based upon actual utilization and will be paid as a percentage increase above the contracted rate between the MCO and the hospital.

(i) Determination of percentage of rate increase.

(1) HHSC will determine the percentage of rate increase applicable to one or more classes of hospital by program component.

(A) UHRIP rate increases will be determined by HHSC to be the percentage that is estimated to result in payments for the class that are equivalent to the amount described under subsection (g)(2)(A) of this section.

(B) ACIA will be determined by HHSC to be a percentage that is estimated to result in payments for the hospital that are equivalent to the amount described under subsection (g)(3)(A) of this section.

(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 subsection (j)(3) of this section. 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 §353.1301(g) of this subchapter, 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 SDA to direct the percentage rate increases.

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

(1) HHSC will communicate suggested IGT responsibilities for the program period with all CHIRP hospitals at least 10 days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars to be available under the CHIRP program for the program period as determined by HHSC, plus eight percent; and forecast member months for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under CHIRP for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled hospitals will meet 100 percent of their quality metrics and maintain consistent utilization with the prior year.

(2) Sponsoring governmental entities will determine the amount of IGT they intend to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC no later than 15 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity intends to transfer to HHSC.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. Sponsoring governmental entities will transfer the second half of the IGT amount by a date determined by HHSC, but no later than December 1. HHSC will publish the IGT deadlines and all associated dates on its Internet website no later than March 15 of each year.

(k) 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.

(l) 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.

(m) 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.

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

§353.1307. Quality Metrics and Required Reporting Used to Evaluate the Success of the Comprehensive Hospital Increase Reimbursement Program.

(a) Introduction. This section establishes the quality metrics and required reporting that may be used in the Comprehensive Hospital Increase Reimbursement Program (CHIRP).

(b) Definitions. The following definitions apply when the terms are used in this section and in metrics and performance requirements developed under subsections (e) and (f) of this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1306 of this subchapter (relating to the Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021).

(1) Baseline--An initial standard used as a comparison against performance in each metric throughout the program period to determine progress in the CHIRP quality metrics.

(2) Benchmark--A metric-specific initial standard set prior to the start of the program period and used as a comparison against an individual hospital or hospital class's progress throughout the program period.

(3) Measurement period--The time period used to measure achievement of a quality metric.

(c) Quality metrics. For each program period, HHSC will designate one or more quality metrics that HHSC will evaluate for each CHIRP capitation rate component as described in §353.1306(g) of this subchapter.

(1) Each quality metric will be identified as a structure measure or a pay-for-reporting (P4R) measure.

(2) Each quality metric will be evidence-based.

(d) Performance requirements. For each program period, HHSC will specify the performance requirement that will be associated with the designated quality metric that is expected to advance at least one of the goals and objectives in the quality strategy. Achievement of performance requirements will be used to evaluate the degree to which the arrangement advances at least one of the goals and objectives that are incentivized by the payments described under §353.1306(g) of this subchapter. For some quality metrics, achievement may be tested merely on whether the class or classes meets or do not meet the established requirement. The following performance requirements are associated with the quality metrics

described in subsection (c) of this section.

(1) Achievement of quality metrics.

(A) The achievement of a structure measure is tested on whether a hospital meets the established requirement.

(B) The achievement of a P4R measure is based on reporting data for a specified measurement period.

(2) Participating Hospital Reporting Frequency.

(A) Participating hospitals will be required to report quarterly unless otherwise specified by the metric. The reported information will be used to conduct interim evaluations of the program.

(B) Participating hospitals will also be required to furnish information and data related to quality measures and performance requirements established in accordance with subsection (e) of this section within 30 calendar days after a request from HHSC for more information.

(e) Notice and hearing.

(1) HHSC will publish notice of the proposed metrics and their associated performance requirements no later than January 31 preceding the first month of the program period. The notice must be published either by publication on HHSC's website or in the *Texas Register.* The notice required under this section will include the following:

(A) instructions for interested parties to submit written comments to HHSC regarding the proposed metrics and performance requirements; and

(B) the date, time, and location of a public hearing.

(2) Written comments will be accepted for 15 business days following publication. There will also be a public hearing within that 15-day period to allow interested persons to present comments on the proposed metrics and performance requirements.

(f) Publication of Final Metrics and Performance Requirements. Final quality metrics and performance requirements will be provided through HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period. If Centers for Medicare and Medicaid Services requires changes to quality metrics or performance requirements after February 28 of the calendar year but before the first month of the program period, HHSC will provide notice of the changes through HHSC’s website.

(g) Evaluation Reports.

(1) HHSC will evaluate the success of the program based on a statewide review of reported metrics. HHSC may publish more detailed information about specific

performance of various participating hospitals, classes of hospitals, or service delivery areas.

(2) HHSC will publish interim evaluation findings regarding the degree to which the arrangement advanced the established goal and objectives of each capitation rate component.

(3) HHSC will publish a final evaluation report within 270 days of the conclusion of the program period.