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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 certain providers that serve Texas Medicaid fee-for-service patients, including 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) 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.

(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 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.

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

(4) Medicare payment gap--The difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services from the most recent FFS upper payment limit (UPL) demonstration.

(5) Nominal charge provider--A provider that charges an amount equal to 60 percent or less of the reasonable cost of service or services. Nominal charges mean Medicare charges are at or below a ratio equal to 0.6 of reasonable costs which equates to a Medicare ratio of cost to charge (RCC) that exceeds 1.67. Charges and costs are based on inpatient hospital services only.

(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.

(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) Payment Methodology. To determine each participating non-state government-owned and operated hospital's payment under this section, HHSC will sum the hospital's inpatient FFS Medicare payment gap and the hospital's outpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid

charges. Nominal charge providers as defined in subsection (b) of this section are exempt from this limitation.

(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) Payment Methodology. To determine each participating private hospital's payment under this section, HHSC will sum the hospital's inpatient FFS Medicare payment gap and the hospital's outpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid charges. Nominal charge

providers as defined in subsection (b) of this section are exempt from this limitation.

(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) Payment Methodology.

(A) To determine payment under this section for each participating state-owned hospital reimbursed through Prospective Payment System (PPS), HHSC will sum the hospital's inpatient FFS Medicare payment gap and the hospital's outpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid charges. Nominal charge providers as defined in subsection (b) of this section are exempt from this limitation.

(B) To determine payment under this section for each participating state-owned hospital not reimbursed through Prospective Payment System (PPS), HHSC will use the hospital's FFS outpatient Medicare payment gap.

(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) Payment Methodology. To determine each participating state government-owned IMD hospital's payment under this section, HHSC will use the hospital's inpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid charges. Nominal charge providers as defined in subsection (b) of this section are exempt from this limitation.

(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) Payment Methodology. To determine each participating private IMD hospital's payment under this section, HHSC will use the hospital's inpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid charges. Nominal charge providers as defined in subsection (b) of this section are exempt from this limitation.

(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.