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TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353. MEDICAID MANAGED CARE

SUBCHAPTER O. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

§353.1306. 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 payor is estimated to pay for the services and what Medicaid actually paid for the same services.

(2) Average Commercial Reimbursement (ACR) Upper Payment Limit (UPL)--A calculated estimation of what an average commercial payor pays for the same Medicaid services.

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

(4) 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.

(5) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness. IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.8060 of this title (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities).

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

(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. 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.

(8) 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.

(9) Rural hospital--A hospital that is a rural hospital as defined in §355.8052 of this title.

(10) 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.

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

(c) Conditions of Participation. 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 the optional program components described in subsections (g)(3) and (g)(4) of this

section. A hospital cannot participate in the program component described in subsection (g)(3) or (g)(4) of this section without also participating in the program component described in subsection (g)(2) of this section. In the application, the hospital must also select whether the hospital elects to receive interim payments described by subsection (h)(2)(D) of this section.

(B) All hospitals must submit certain necessary data to calculate the ACR gap. However, a hospital may indicate that it does not wish to participate in the optional program component described in subsection (g)(3) of this section.

(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.

(D) For a program period that begins on or after September 1, 2021, any hospital that did not report the data described in subparagraph (B) of this paragraph in the application for the program must report the data within four months of Centers for Medicare and Medicaid Services (CMS) approval of the program.

(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 and that the entity's agreement with the hospital does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including 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) 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.

(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.

(5) Failure to meet any conditions of participation described in this subsection will result in removal of the provider from the program and recoupment of all funds previously paid during the program period.

(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 or another

type of payment 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 hospitals;

(E) non-state-owned IMDs; and

(F) state-owned IMDs.

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

(e) Eligibility. HHSC determines eligibility for rate increases and other payments 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 or other payment. HHSC will consider the following factors when identifying the class or classes of hospital eligible for a rate increase or other payment 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 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 and other payment.

(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. For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, CHIRP funds will be paid to MCOs through two components of the managed care per member per month (PMPM) capitation rates. For program periods beginning on or after September 1, 2024, CHIRP funds will be paid to MCOs through three components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of CHIRP 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 (relating to Quality Metrics for the Comprehensive Hospital Increase Reimbursement Program). 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 percentage increases described under subsection (h)(1) 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 the combined Medicare gap of each hospital class within an SDA to the total Medicare gap of all hospital classes within the SDA.

(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, subject to the limitations described by subparagraph (B) of this paragraph.

(B) The maximum ACIA payments for each class will be equal to a percentage of the total estimated ACR UPL for the class, less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA. For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, the percentage is 90 percent. For program periods beginning on or after September 1, 2024, the percentage may not exceed 90 percent.

(C) The ACIA payment for the class will be equal to the minimum of the sum of the ACIA payment in subparagraph (A) of this paragraph and the limit in subparagraph (B) of this paragraph. If the amount calculated under subparagraph (B) of this paragraph is negative, the maximum, aggregated ACIA payments for that class will be equal to zero.

(D) The ACIA payment for each provider will be equal to the amount in subparagraph (A) of this paragraph multiplied by the amount determined in subparagraph (C) of this paragraph for the class divided by the sum of the preliminary ACIA payment determined in subparagraph (A) of this paragraph for the class, rounded down to the nearest percentage. For example, if two hospitals in a class in an SDA both have anticipated base payments of $100 and UHRIP payments of $50, but one hospital has an estimated ACR UPL of

$400 and an ACR gap of $300 between its base payment and ACR UPL, and the other hospital has an estimated ACR UPL of $600 and an ACR gap of $500, HHSC will first reduce the gaps by the UHRIP payment of $50 to a gap of $250 and $450, respectively. The preliminary ACIA rates are 250 percent and 450 percent. These are the amounts available under subparagraph (A) of this paragraph. HHSC would then sum the ACR UPLs for the two hospitals to get $1000 available to the class and apply the percentage in subparagraph (B) of this paragraph (e.g., 50 percent of the gap), which results in an ACR UPL of $500. Then HHSC will subtract the $200 in base payments and $100 in UHRIP payments from the reduced ACR UPL for a total of $200 of maximum ACIA payments under subparagraph (B) of this paragraph. The amount under subparagraph (A) for the class was $700, and the limit under subparagraph (B) of this paragraph is $200, so all provider in the SDA will have their ACIA percentage multiplied by $200 divided by $700 to stay under the $200 cap. The individual ACIA rates would be 71 percent (e.g., 200/700*250 percent) and 128 percent (e.g., 200/700*450 percent), respectively. The estimated ACIA payments would be $71 and $128. HHSC will then direct the MCOs to pay a percentage increase for the first hospital of 71 percent in addition to the 50 percent increase under UHRIP for the first hospital for a total increase of 121 percent above the contracted base rate, and 128 percent in addition to the 50 percent increase under UHRIP for the second hospital for a total increase of 178 percent.

(4) For program periods beginning on or after September 1, 2024, the Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA) is the third component.

(A) The total value of APHRIQA will be equal to the sum of:

(i) a percentage of the Medicare gap, not to exceed 100 percent, on a per class basis less the amount determined in paragraph (2)(A) of this subsection; and

(ii) a percentage of the total estimated ACR UPL, not to exceed 90 percent, on a per class basis less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA and less any payments received under ACIA.

(B) Allocation of funds across hospitals will be calculated by allocating to each hospital the sum of:

(i) the difference in the amount the hospital is estimated to be paid under paragraph (2)(A) of this subsection and the amount they would be paid if the percentage described in paragraph (2)(A) of this subsection were the same percentage cited in subparagraph (A)(i) of this paragraph; and

(ii) the difference in the amount the hospital is estimated to be paid under paragraph (3)(C) of this subsection and the amount they would be paid if the percentage described in paragraph (3)(B) of this subsection were the same percentage cited in subparagraph (A)(ii) of this paragraph.

(h) Distribution of CHIRP payments.

(1) CHIRP payments for UHRIP and ACIA components will be based upon actual utilization and will be paid as a percentage increase above the contracted rate between the MCO and the hospital. The determination of percentage of rate increase will be as follows.

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

(B) 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.

(C) 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)(D) of this section.

(2) For program periods beginning on or after September 1, 2024, CHIRP final payments for the APHRIQA component will be based on achievement of performance measures established in accordance with §353.1307 of this subchapter.

(A) Except as otherwise provided by subparagraph (D) of this paragraph, MCOs will be directed by HHSC to pay hospitals on a monthly, quarterly, semi-annual, or annual basis that aligns with the applicable performance achievement measurement period under §353.1307 of this subchapter.

(B) MCOs will be required to distribute payments to providers within 20 business days of notification by HHSC of provider achievement results.

(C) Funds that are not earned by a provider due to failure to achieve performance requirements will be redistributed to other hospitals in the same hospital SDA and class based on each hospital's proportion of total earned APHRIQA funds in the SDA. If no other hospital in the SDA and class receives performance payments, unearned funds will be redistributed to all hospitals in the SDA based on each hospital's proportion of total earned APHRIQA funds and projected to be paid to the hospitals through UHRIP and ACIA.

(D) For any performance measures for which achievement is determined on an annual basis, a hospital may elect, on the hospital's enrollment application, to

receive two interim payments the amount of each which will be equal to 20 percent of the total estimated value of the hospital's potential APHRIQA payment if the hospital were to earn 100 percent of available payments under the APHRIQA component.

(i) Any interim payments will be reconciled with final payment for APHRIQA after measurement achievement has been determined under §353.1307 of this subchapter. If a hospital's final payment is calculated to be less than the amount that the hospital was paid on an interim basis, the interim payments are subject to recoupment as described by this subparagraph. If a hospital's final payment is calculated to be greater than the amount that the hospital was paid on an interim basis, the hospital's final payment will be an amount equal to the amount the hospital earned for measurement achievement under §353.1307 of this subchapter minus the amount the hospital was paid on an interim basis.

(ii) Prior to the beginning of the program period, for hospitals that make the election described by this subparagraph, HHSC will calculate the total estimated value of the hospital's potential APHRIQA payment if the provider were to earn 100 percent of available payments under the APHRIQA component. MCOs will distribute interim payments described by this subparagraph to enrolled hospitals as directed by HHSC.

(iii) Interim payments made under this subparagraph are not an indication of presumed measurement achievement by a provider under §353.1307 of this subchapter.

(iv) If a provider is notified by HHSC that an interim payment, or any portion of an interim payment, is being recouped under this subparagraph, the provider must return all funds subject to recoupment to the MCO that made the interim payment subject to recoupment within 20 business days of notification by HHSC.

(3) HHSC will limit the amounts paid to providers determined pursuant to this subsection to no more than the levels that are supported by the amount described in subsection (i)(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.

(4) After determining the percentage of rate increase using the process described in paragraph (1) of this subsection, HHSC will modify its contracts with the MCOs in the SDA to direct the percentage rate increases.

(i) 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 calendar 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 21 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) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred no fewer than 14 business days before IGT transfers are due. 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.

(j) 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.

(k) 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.

(l) Data correction request. Any provider-requested data or calculation correction must be submitted prior to the date on which the first half of the IGT amount is due under subsection (i)(3) of this section.

(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.