TO: Medical Care Advisory Committee

DATE: August 24, 2017

FROM: Charles Greenberg,
Director of Policy
Office of the Chief Counsel, HHSC

Agenda Item No.: 8

SUBJECT: Amendments to Disallowance Provisions in Directed Payment General Provisions

Amendments to: Title 1, Part 15, Chapter 353, Subchapter O, §353.1301, General Provisions

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

In March of 2017, HHSC adopted a series of rules governing delivery system and provider payment initiatives through Medicaid managed care organizations (MCOs) (42 TexReg 13). These initiatives are, generally, funded through intergovernmental transfers (IGT) from local governmental entities. Given that these programs are not funded with state general revenue, HHSC must ensure, to the greatest extent possible, that no state dollars are at risk through the operation of these programs. A disallowance by the Centers for Medicare & Medicaid Services (CMS) is one potential risk to general revenue, unless HHSC can ensure that funds from another source are available.

Section 353.1301(j) describes the procedure HHSC would use in the case of a disallowance. The rule delineates between a disallowance for impermissible provider-related donations and all other disallowances. At present, if there is a disallowance for impermissible provider-related donations, the rule requires HHSC to recoup the disallowed amount from transferring governmental entities that caused the disallowance. If there is a disallowance for reasons other than an impermissible provider-related donation, HHSC reserves the right to recoup the disallowed amount from MCOs, providers, or governmental entities.

In an effort to provide HHSC more flexibility when determining the appropriate entity from which to recoup, HHSC proposes to amend §353.1301 to remove the requirement that it recoup only from governmental entities in the case of a disallowance for impermissible provider-related donations. Instead, HHSC will reserve the right to recoup from MCOs, providers, or governmental entities in any disallowance. In order to ensure that there is no risk to general revenue, to the greatest extent

possible, HHSC will require that if a recoupment for a disallowance results in a subsequent disallowance, the entity that HHSC initially recouped against will face a recoupment for the subsequent disallowance.

In addition, HHSC will clarify the heading for §353.1301(k) by changing the name from “Recoupment” to “Overpayment.”

ISSUES AND ALTERNATIVES:

Stakeholders might want to narrow who would be responsible for a recoupment in the case of a disallowance for impermissible provider-related donations. The rule amendment, however, grants HHSC the flexibility necessary to assess the situation and find the appropriate entity to recoup against.

STAKEHOLDER INVOLVEMENT:

Stakeholders initially brought the issue to HHSC and requested an amendment.

FISCAL IMPACT:

☒ None ☐ Yes

RULE DEVELOPMENT SCHEDULE:

August 18, 2017	Publish proposed rules in *Texas Register*
August 24, 2017	Present to Medical Care Advisory Committee
September 7, 2017	Present to HHSC Executive Council
October 20, 2017	Publish adopted rules in *Texas Register*
October 30, 2017	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
RULE §353.1301 GENERAL PROVISIONS

PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes amendments to §353.1301, concerning General Provisions.

BACKGROUND AND PURPOSE

In March of 2017, HHSC adopted a series of rules governing delivery system and provider payment initiatives through Medicaid managed care organizations (MCOs) (42 *TexReg* 13). These initiatives are, generally, funded through intergovernmental transfers (IGT) from local governmental entities. Given that these programs are not funded with state general revenue, HHSC must ensure, to the greatest extent possible, that no state dollars are at risk through the operation of these programs. A disallowance by the Centers for Medicare & Medicaid Services (CMS) is one potential risk to general revenue, unless HHSC can ensure that funds from another source are available.

Section 353.1301(j) describes the procedure HHSC would use in the case of a disallowance. The rule delineates between a disallowance for impermissible provider-related donations and all other disallowances. At present, if there is a disallowance for impermissible provider-related donations, the rule requires HHSC to recoup the disallowed amount from transferring governmental entities that caused the disallowance. If there is a disallowance for reasons other than an impermissible provider-related donation, HHSC reserves the right to recoup the disallowed amount from MCOs, providers, or governmental entities.

In an effort to provide HHSC more flexibility when determining the appropriate entity from which to recoup, HHSC proposes to amend §353.1301 to remove the requirement that it recoup only from governmental entities in the case of a disallowance for impermissible provider-related donations. Instead, HHSC will reserve the right to recoup from MCOs, providers, or governmental entities in any disallowance. In order to ensure that there is no risk to general revenue, to the greatest extent possible, HHSC will require that if a recoupment for a disallowance results in a subsequent disallowance, the entity that HHSC initially recouped against will face a recoupment for the subsequent disallowance.

In addition, HHSC will clarify the heading for §353.1301(k) by changing the name from “Recoupment” to “Overpayment.”

SECTION-BY-SECTION SUMMARY

Proposed amendments to §353.1301(b) add the acronym “SDA” to the definition of “service delivery area.”

Proposed amendments to §353.1301(j) change the requirements for recoupments in the case of a disallowance for impermissible provider-related donations. Further, the amendments require the same entities that pay for any initial disallowance to pay for subsequent recoupments resulting from that initial disallowance.

Proposed amendment to §353.1301(k) changes the heading for the subsection from “Recoupment” to “Overpayment.”

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years that the amendment will be in effect, there are no anticipated implications to costs or revenues of state or local governments as a result of enforcing and administering the rule as proposed.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

Ms. Rymal has also determined that there is no anticipated adverse economic impact on small businesses or micro-businesses required to comply with the changes to the section proposed. Participants referred to in this rule are hospitals and nursing facilities. No Texas hospital meets the definition of a small business or micro-business. Nursing facility participation in the programs described in this subchapter is voluntary.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the amendment as proposed.

There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

Pam McDonald, Director of Rate Analysis, has determined that for each year of the first five years the amendment is in effect, the public will benefit from adoption of the amendment. The public benefit anticipated as a result of enforcing or administering the amendment is that HHSC will have greater flexibility in determining the appropriate entity from which to recoup funds in the event of a disallowance. Further, the public will benefit from the greater certainty surrounding general revenue.

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 Government Code, §2007.043.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Charles Greenberg, Director of Policy for Legal Services, 4900 N. Lamar Blvd., Mail Code 1100, Austin, Texas 78751; by fax to (512)-(424-6586); or by e-mail to charles.greenberg@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

To be considered, comments must be submitted no later than 30 days after the date of this issue of the *Texas Register*. The last day to submit comments falls on a Sunday; therefore, comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 1R061" in the subject line.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with board rulemaking authority; 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), 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 with Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

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.

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

§353.1301. General Provisions.

(a) Purpose. The purpose of this subchapter is to describe the circumstances and programs under which the Texas Health and Human Services Commission may direct expenditures for delivery system and provider payment initiatives through its contracts with Medicaid managed care organizations. Federal authority for such directed expenditures is codified at 42 C.F.R. §438.6(c).

(b) Definitions. The following definitions apply when the terms are used in this subchapter. Terms that are used in only one program described in this subchapter may be defined in the section of this subchapter describing that program.

(1) Capitation rate--A fixed, predetermined fee paid by HHSC to the managed care organization each month, in accordance with the contract, for each enrolled member. In exchange for this, the managed care organization arranges for or provides a defined set of covered services to the enrolled member, regardless of the amount of covered services used by the enrolled member.

(2) Centers for Medicare & Medicaid Services (CMS)--The federal agency within the United States Department of Health and Human Services responsible for overseeing and directing Medicare and Medicaid.

(3) HHSC--The Texas Health and Human Services Commission or its designee.

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

(5) Managed care organization (MCO)--A Medicaid managed care organization contracted with HHSC to provide health care services to Medicaid recipients.

(6) Non-federal share--The portion of program expenditures that is not federal funds. The non-federal share is equal to 100 percent minus the federal medical assistance percentage (FMAP) for Texas for the state fiscal year corresponding to the program year and for the population served.

(7) Non-state governmental entity--A hospital authority, hospital district, health district, city, or county.

(8) Program rate component--The fixed percentage of the capitation rate that is attributable to the delivery system or provider payment initiative.

(9) Provider--A credentialed and licensed individual, facility, agency, institution, organization, or other entity that has a contract with the MCO for the delivery of covered services to the MCO's members.

(10) Public funds--Funds derived from taxes, assessments, levies, and investments. Public funds also include other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(11) Service delivery area (SDA)--The counties included in any HHSC-defined geographic area as applicable to each MCO.

(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.

(c) CMS approval. Implementation of each of the programs described in this subchapter is contingent upon HHSC receiving written approval from CMS of the contract provisions directing the MCO expenditures. Federal requirements for CMS approval of directed MCO expenditures are codified in 42 C.F.R. §438.6(c)(2).

(d) Program specifications, provider eligibility, and payment calculations. Descriptions of program specifications, provider eligibility, and payment calculations are contained in the sections of this subchapter that describe each delivery system or provider payment initiative program.

(e) Source of the non-federal share. The non-federal share of expenditures under this subchapter is limited to timely receipt by HHSC of public funds from sponsoring governmental entities.

(1) State-owned providers. A state-owned provider may transfer to HHSC any non-federal funds within the control of the provider, including appropriated state general revenue funds, as the non-federal share of program expenditures associated with that provider.

(2) All other providers. For all other providers, the non-federal share of program expenditures is funded through IGTs. No state general revenue appropriated to HHSC is available to support program expenditures to non-state providers under this subchapter.

(f) Amount and timing of transfer of the non-federal share. The amount of the non-federal share that governmental entities transfer to HHSC for expenditures under this subchapter and the timing of such transfers are specific to each delivery system or provider payment initiative and are described in the section of this subchapter governing each such program.

(g) Reconciliation of the non-federal share.

(1) Purpose. The amount of HHSC's expenditures under this subchapter is dependent on member enrollment in each participating MCO, which may fluctuate from month to month. HHSC's actual expenditures cannot be determined until final member enrollment data is available, which may not occur for up to two years following the end of the program period. The purpose of the reconciliation process is to ensure that HHSC's actual total expenditures for each program are determined based on accurate and final member enrollment data for each program period, and that the non-federal share of HHSC's actual expenditures are borne by the appropriate governmental entity or entities.

(2) Methodology. For each program described in this subchapter, HHSC reconciles the amount of the non-federal funds actually expended during the program period with the amount of funds transferred to HHSC by the sponsoring governmental entities. For programs with multiple provider classes, HHSC reconciles expenditures for each provider class. HHSC completes each reconciliation in multiple parts.

(A) The first reconciliation occurs no later than 120 days after the end of the program period.

(i) Using the best-available member enrollment data at the time of the first reconciliation, HHSC:

(I) calculates the amount expended for the program period by multiplying the program rate component by the total member months included in the program period;

(II) calculates the non-federal share of the amount determined in subclause (I) of this clause; and

(III) compares the amount determined in subclause (II) of this clause to the amount previously transferred to HHSC by the participating governmental entities for the program period.

(ii) If the amount previously transferred is less than 102 percent of the amount determined in clause (i)(II) of this subparagraph:

(I) the participating governmental entities must transfer additional funds to HHSC such that total transferred funds equals 102 percent of the amount determined in clause (i)(II) of this subparagraph;

(II) if more than one governmental entity is responsible for the non-federal share of payments under the program, the additional required funds are allocated proportional to each governmental entity's initial contribution to funding the program; and

(III) HHSC notifies the governmental entities of the amount and timing of the required transfers.

(iii) If the amount previously transferred is more than 102 percent of the amount determined in clause (i)(II) of this subparagraph, HHSC refunds the excess amount to the governmental entities in proportion to each entity's initial contribution to funding the program.

(B) Interim reconciliations may occur as updated member enrollment data for the program period becomes available. HHSC follows the process described in subparagraph (A) of this paragraph for such interim reconciliations.

(C) The final reconciliation occurs no later than 25 months after the end of the program period.

(i) Using the final member enrollment data for the program period, HHSC:

(I) calculates the amount expended for the program period by multiplying the program rate component by the total member months included in the program period;

(II) calculates the non-federal share of the amount determined in subclause (I) of this clause; and

(III) compares the amount determined in subclause (II) of this clause to the amount previously transferred to HHSC by the sponsoring governmental entities for the program period, including any amounts transferred pursuant to subparagraphs (A)(ii) or (B) of this paragraph.

(ii) If the amount previously transferred is less than the non-federal share of the amount expended:

(I) the participating governmental entities must transfer additional funds to HHSC such that total transferred funds equals the amount determined in clause (i)(II) of this subparagraph;

(II) if more than one governmental entity is responsible for the non-federal share of payments under the program, the additional required funds are allocated proportional to each governmental entity's initial contribution to funding the program; and

(III) HHSC notifies the governmental entities of the amount and timing of the required transfers.

(iii) If the amount previously transferred is more than the amount determined in clause (i)(II) of this subparagraph, HHSC refunds the excess amount to the governmental entities in proportion to each entity's initial contribution to funding the program.

(h) Failure of a governmental entity to transfer funds. If a governmental entity does not timely complete the transfer of funds described in this section, HHSC withholds Medicaid payments from any provider operated by the governmental entity until HHSC has recovered an amount equal to the amount of the funding shortfall.

(i) Failure of an MCO to comply with contract provisions. HHSC may review MCO payments to network providers or other documentation to verify that the MCO is in compliance with contract provisions directing expenditures for delivery system and provider payment initiatives. HHSC must investigate provider claims of contract violations. In the event HHSC identifies any contract deficiency or violation, HHSC takes corrective action to remedy such

deficiency or violation, as authorized by §353.5 of this chapter (relating to Internet Posting of Sanctions Imposed For Contractual Violations).

(j) Disallowance of federal funds.

[~~(1) If an arrangement associated with the funding of payments under this subchapter is determined by CMS to constitute an impermissible provider donation, resulting in a disallowance of federal matching funds, the governmental entities responsible for the non-federal share of such payments must transfer funds to HHSC in the amount of the disallowed federal funds. HHSC notifies the governmental entities of the amount and timing of the required transfers.~~]

[~~(2)~~] If payments under this subchapter are disallowed by CMS [~~on grounds other than those described in paragraph (1) of this subsection, to the extent allowed by federal and state law and contract~~], HHSC may recoup the amount of the disallowance from MCOs, providers, or governmental entities that participated in the program associated with the disallowance. If the recoupment from an MCO, provider, or governmental entity for such a disallowance results in a subsequent disallowance, HHSC will recoup the amount of that subsequent disallowance from the same entity.

(k) Overpayment. [~~Recoupment.~~]

(1) If payments under this subchapter result in an overpayment to an MCO, HHSC may recoup the amount of the overpayment from the MCO, pursuant to the terms of the contract between them.

(2) If payments under this subchapter result in an overpayment to a provider, the MCO may recoup an amount equivalent to the overpayment.

(3) Payments made under this subchapter may be subject to any adjustments for payments made in error or due to fraud, including without limitation adjustments made under the Texas Administrative Code, the Code of Federal Regulations, and state and federal statutes. The MCOs may recoup an amount equal to any such adjustments from the providers in question. Nothing in this section may be construed to limit the independent authority of another federal or state agency or organization to recover from the provider for a payment made due to fraud.

(l) State's cost of administering programs. To the extent authorized under state and federal law, HHSC will collect the state's cost of administering a program authorized under this subchapter from participants in the program generating the costs.