



TO: Medical Care Advisory Committee
DATE: 8/24/2017
FROM: Selvadas Govind
Director of Rate Analysis for Hospitals
Rate Analysis Department, HHSC

Agenda Item No.: 9

SUBJECT: Amendments to Uniform Hospital Rate Increase Program

Amendments to: Texas Administrative Code Title 1, Part 15, Chapter 353, Subchapter O, §353.1305, concerning the Uniform Hospital Rate Increase Program

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

In March of 2017, HHSC adopted rules governing a provider payment initiative through Medicaid managed care organizations (MCOs) called the Uniform Hospital Rate Increase Program (UHRIP) (42 *TexReg* 1748). Under the UHRIP initiative, a service delivery area (SDA) may apply to receive an increase in certain hospital rates which would vary by class of hospital. Although UHRIP was to begin in September 2017 and be available to any SDA, operational issues necessitated a delay. Such issues included lack of readiness by MCOs, lack of program understanding among providers, and incomplete approvals from the Centers for Medicare and Medicaid Services (CMS). HHSC proposes to amend the UHRIP rule in three ways.

First, HHSC proposes to amend §353.1305(b)(7) and (8), the definitions of "rural private hospital" and "rural public hospital" to be consistent with a revised definition of "rural hospital" that was adopted in §355.8052 (relating to Inpatient Hospital Reimbursement) to be effective September 1, 2017. The definitions in this rule would now refer to the definition of "rural hospital" in §355.8052.

Second, HHSC proposes to add §353.1305(k) which would allow for a limited December 1, 2017, entry into UHRIP for a subset of SDAs. Specifically, if HHSC received an approval from CMS for any particular SDA by April 15, 2017, that SDA would be able to participate in UHRIP for dates of service beginning December 1, 2017.

Third, HHSC standardizes references to SDAs throughout the section.

ISSUES AND ALTERNATIVES:

Stakeholders might wish to allow more SDAs into the program on December 1. However, due to time and contracting constraints, HHSC cannot allow any SDAs to participate that did not receive CMS' approval as of April 15, 2017.

STAKEHOLDER INVOLVEMENT:

Two SDAs approached HHSC with the possibility of a UHRIP entry date earlier than March 1, 2018.

FISCAL IMPACT:

None Yes

RULE DEVELOPMENT SCHEDULE:

August 2017	Present to Hospital Payment Advisory Committee
August 2017	Publish proposed rules in <i>Texas Register</i>
August 2017	Present to Medical Care Advisory Committee
September 2017	Present to HHSC Executive Council
November 2017	Publish adopted rules in <i>Texas Register</i>
December 1, 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

PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1305, concerning Uniform Hospital Rate Increase Program.

BACKGROUND AND PURPOSE

In March of 2017, HHSC adopted rules governing a provider payment initiative through Medicaid managed care organizations (MCOs) called the Uniform Hospital Rate Increase Program (UHRIP) (42 TexReg 1748). Under the UHRIP initiative, a service delivery area (SDA) may apply to receive an increase in certain hospital rates which would vary by class of hospital. Although UHRIP was to begin in September 2017 and be available to any SDA, operational issues necessitated a delay. Such issues included lack of readiness by MCOs, lack of program understanding among providers, and incomplete approvals from the Centers for Medicare & Medicaid Services (CMS). HHSC proposes to amend the UHRIP rule in three ways.

First, HHSC proposes to amend §353.1305(b)(7) and (8), the definitions of "rural private hospital" and "rural public hospital," to be consistent with a revised definition of "rural hospital" that was adopted in §355.8052 (relating to Inpatient Hospital Reimbursement) to be effective September 1, 2017. The definitions in this rule would now refer to the definition of "rural hospital" in §355.8052.

Second, HHSC proposes to add §353.1305(k), which would allow for a limited December 1, 2017, entry into UHRIP for a subset of SDAs. Specifically, if HHSC received an approval from CMS for any particular SDA by April 15, 2017, that SDA would be able to participate in UHRIP for dates of service beginning December 1, 2017.

Third, HHSC standardizes references to SDA throughout the section.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.1305(a) adds an acronym for "service delivery area."

The proposed amendment to §353.1305(b) changes the definitions of "rural private hospital" and "rural public hospital" to refer to the definition of "rural hospital" in §355.8052. The proposed amendment also changes "service delivery area" to the acronym "SDA."

The proposed amendment to §353.1305(c), (d), (e), (f), and (g) changes "service delivery area" to the acronym "SDA."

Proposed new §353.1305(k) allows SDAs that received participation approval from CMS by April 15, 2017, to implement UHRIP for dates of service beginning December 1, 2017.

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 will be no fiscal implications to state government as a result of enforcing or administering the amendment as proposed. There may be fiscal implications to local governments, but there is insufficient information to provide an estimate because HHSC does not know which non-state governmental entities will voluntarily sponsor rate increases under this section or at what level of funding.

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

Ms. Rymal has also determined that there will be no adverse impact on small businesses, micro-businesses, or rural communities required to comply with the amendment as proposed. To the extent any entity is economically impacted by this rule, the impact would be positive.

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 amended rule 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 areas of the state that

received early UHRIP-related approvals from CMS will have access to enhanced Medicaid payments for hospital services. An additional public benefit is that the definitions of "rural" hospitals will be consistent across multiple reimbursement programs and in the administrative rules associated with those programs.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

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 HEARING

A public hearing is scheduled for September 27, 2017, at 9:30 a.m. (central time) in the Brown Heatly Building Public Hearing Room 1410, at 4900 North Lamar Blvd., Austin, Texas. Persons requiring further information, special assistance, or accommodations should contact Selvadas Govind at (512) 707-6080.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Kevin Niemeyer, HHS Rate Analysis, P.O. Box 149030, Mail Code H-400, Brown-Heatly Building, 4900 N. Lamar Blvd., Austin, Texas 78714-9030; by fax to (512) 730-7475; or by e-mail to kevin.niemeyer@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

To ensure that the comments will 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 UHRIP" in the subject line.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad 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.

The proposed amendment implements Texas Human Resources Code, Chapter 32; Texas Government Code, Chapter 531; and Texas Government Code, Chapter 533. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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.

(a) Introduction. This section describes the circumstances 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 [~~A service delivery area~~] 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). [~~located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated rural referral center, a sole community hospital, or a critical access hospital.~~]

(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. [~~located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated rural referral center, a sole community hospital, or a critical access hospital.~~]

(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 [~~a service delivery area~~] 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; and

(G) all other hospitals, except institutions for mental diseases.

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

(d) Eligibility. HHSC determines eligibility for rate increases by SDA [~~service delivery area~~] and class of hospital.

(1) Service delivery area. Only hospitals in an SDA [~~a service delivery area~~] 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 [~~service delivery area~~] 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. HHSC may direct the MCOs in an SDA [~~a service delivery area~~] 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.

(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 section 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 [~~service-delivery-area~~] to direct the percentage rate increases.

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

(1) The stakeholders in an SDA [~~a-service-delivery-area~~] 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 [~~service-delivery-area~~], 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 [~~service delivery area~~]. 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.

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