Texas Administrative Code rule amendments as part of the transition to managed care for the Medicaid Breast and Cervical Cancer, Adoption Assistance, and Permanency Care Assistance populations

§353.2 Definitions

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Action--

(A) An action is defined as:

(i) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(ii) the reduction, suspension, or termination of a previously authorized service;

(iii) the failure to provide services in a timely manner;

(iv) the denial in whole or in part of payment for a service; or

(v) the failure of a managed care organization (MCO) to act within the timeframes set forth by the Health and Human Services Commission (HHSC) and state and federal law.

(B) "Action" does not include expiration of a time-limited service.

(2) Acute care--Preventive care, primary care, and other medical or behavioral health care provided by the provider or under the direction of a provider for a condition having a relatively short duration.

(3) Acute care hospital--A hospital that provides acute care services.

(4) Agreement or Contract--The formal, written, and legally enforceable contract and amendments thereto between HHSC and an MCO.

(5) Allowable revenue--All managed care revenue received by the MCO pursuant to the contract during the contract period, including retroactive adjustments made by HHSC. This would include any revenue earned on Medicaid managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated networks.
(6) Appeal--The formal process by which a member or his or her representative requests a review of the MCO's action.

(7) Behavioral health service--A covered service for the treatment of mental, emotional, or substance use disorders.

(8) Capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is responsible for payment.

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


(11) Children's Medicaid Dental Services--The dental services provided through a dental MCO to a client birth through age 20.

(12) Clean claim--A claim submitted by a physician or provider for health care services rendered to a member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as further defined under the terms of the contract executed between the MCO and HHSC.

(13) Client--Any Medicaid-eligible recipient.

(14) CMS--The Centers for Medicare & Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

(15) Complainant--A member, or a treating provider or other individual designated to act on behalf of the member, who files a complaint.

(16) Complaint--Any dissatisfaction expressed by a complainant, orally or in writing, to the MCO about any matter related to the MCO other than an action. Subjects for complaints may include:

(A) the quality of care of services provided;

(B) aspects of interpersonal relationships such as rudeness of a provider or employee; and

(C) failure to respect the member's rights.

(17) Consumer Directed Services (CDS) option--A service delivery option (also known as self-directed model with service budget) in which an individual or legally authorized
representative employs and retains service providers and directs the delivery of certain program services.

(18) Covered services--Unless a service or item is specifically excluded under the terms of the state plan, a federal waiver, a managed care services contract, or an amendment to any of these, the phrase "covered services" means all health care, long term services and supports, or dental services or items that the MCO must arrange to provide and pay for on a member's behalf under the terms of the contract executed between the MCO and HHSC, including:

(A) all services or items comprising "medical assistance" as defined in §32.003 of the Human Resources Code; and

(B) all value-added services under such contract.

(19) Cultural competency--The ability of individuals and systems to provide services effectively to people of various disabilities, cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

(20) Day--A calendar day, unless specified otherwise.

(21) Default enrollment--The process established by HHSC to assign a Medicaid managed care enrollee to an MCO when the enrollee has not selected an MCO.

(22) Dental managed care organization (dental MCO)--A dental indemnity insurance provider or dental health maintenance organization licensed or approved by the Texas Department of Insurance.

(23) Dental contractor--A dental MCO that is under contract with HHSC for the delivery of dental services.

(24) Dental home--A provider who has contracted with a dental MCO to serve as a dental home to a member and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as dental homes are federally qualified health centers and individuals who are general dentists or pediatric dentists.

(25) Dental service--The routine preventive, diagnostic, urgent, therapeutic, initial, and primary care provided to a member and included within the scope of HHSC's agreement with a dental contractor. For purposes of this chapter, "dental service" does not include dental devices for craniofacial anomalies; treatment rendered in a hospital, urgent care center, or ambulatory surgical center setting for craniofacial anomalies; or emergency services provided in a hospital, urgent care center, or ambulatory surgical center setting involving dental trauma. These types of services are treated as health care services in this chapter.
(26) Disability--A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, socializing, or working.

(27) Disproportionate Share Hospital (DSH)--A hospital that serves a higher than average number of Medicaid and other low-income patients and receives additional reimbursement from the State.

(28) Dual eligible--A Medicaid recipient who is also eligible for Medicare.

(29) Elective enrollment--Selection of a primary care provider (PCP) and MCO by a client during the enrollment period established by HHSC.

(30) Emergency behavioral health condition--Any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

(A) requires immediate intervention and/or medical attention without which the client would present an immediate danger to themselves or others; or

(B) renders the client incapable of controlling, knowing, or understanding the consequences of his or her actions.

(31) Emergency medical condition--A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) serious jeopardy to the health of a pregnant woman or her unborn child.

(32) Emergency service--A covered inpatient and outpatient service, furnished by a network provider or out-of-network provider that is qualified to furnish such service, that is needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. For health care MCOs, the term "emergency service" includes post-stabilization care services.
(33) **Encounter**--A covered service or group of covered services delivered by a provider to a member during a visit between the member and provider. This also includes value-added services.

(34) **Enrollment**--The process by which an individual determined to be eligible for Medicaid is enrolled in a Medicaid MCO serving the service area in which the individual resides.

(35) **EPSDT**--The federally mandated Early and Periodic Screening, Diagnosis and Treatment program defined in 25 TAC Chapter 33. The State of Texas has adopted the name Texas Health Steps (THSteps) for its EPSDT program.

(36) **EPSDT-CCP**--The Early and Periodic Screening, Diagnosis and Treatment-Comprehensive Care Program described in Chapter 363 of this title (relating to Texas Health Steps Comprehensive Care Program).

(37) **Exclusive provider benefit plan (EPBP)**--An MCO that complies with 28 TAC §§3.9201 - 3.9212, relating to the Texas Department of Insurance's requirements for EPBPs, and contracts with HHSC to provide Medicaid coverage.

(38) **Experience rebate**--The portion of the MCO's net income before taxes that is returned to the State in accordance with the MCO's contract with HHSC.

(39) **Fair hearing**--The process adopted and implemented by HHSC in Chapter 357, Subchapter A of this title (relating to Uniform Fair Hearing Rules) in compliance with federal regulations and state rules relating to Medicaid fair hearings.

(40) **Federally Qualified Health Center (FQHC)**--An entity that is certified by CMS to meet the requirements of 42 U.S.C. §1395x(aa)(3) as a Federally Qualified Health Center and is enrolled as a provider in the Texas Medicaid program.

(41) **Federal Poverty Level (FPL)**--The household income guidelines issued annually and published in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. §9902(2) and as in effect for the applicable budget period determined in accordance with 42 C.F.R. §435.603(h). HHSC uses the FPL to determine an individual's eligibility for Medicaid.

(42) **Federal waiver**--Any waiver permitted under federal law and approved by CMS that allows states to implement Medicaid managed care.

(43) **Former Foster Care Children (FFCC) program**--The Medicaid program for young adults who aged out of the conservatorship of Texas Department of Family and Protective Services (DFPS), administered in accordance with Chapter 366, Subchapter J of this title (relating to Former Foster Care Children's Program).
(44) Functional necessity--A member's need for services and supports with activities of daily living or instrumental activities of daily living to be healthy and safe in the most integrated setting possible. This determination is based on the results of a functional assessment.

(45) Habilitation--Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks based on the individual's person-centered service plan.

(46) Health care managed care organization (health care MCO)--An entity that is licensed or approved by the Texas Department of Insurance to operate as a health maintenance organization or to issue an EPBP.

(47) Health care services--The acute care, behavioral health care, and health-related services that an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, emergency services and inpatient and outpatient services.

(48) Health and Human Services Commission (HHSC)--The single state agency charged with administration and oversight of the Texas Medicaid program or its designee.

(49) Health maintenance organization (HMO)--An organization that holds a certificate of authority from the Texas Department of Insurance to operate as an HMO under Chapter 843 of the Texas Insurance Code, or a certified Approved Non-Profit Health Corporation formed in compliance with Chapter 844 of the Texas Insurance Code.

(50) Hospital--A licensed public or private institution as defined in the Texas Health and Safety Code at Chapter 241, relating to hospitals, or Chapter 261, relating to municipal hospitals.

(51) Intermediate care facility for individuals with an intellectual disability or related condition (ICF-IID)--A facility providing care and services to individuals with intellectual disabilities or related conditions as defined in §1905(d) of the Social Security Act (42 U.S.C. 1396(d)).

(52) Legally authorized representative (LAR)--A person authorized by law to act on behalf of an individual with regard to a matter described in this chapter, and may, depending on the circumstances, include a parent, guardian, or managing conservator of a minor, or the guardian of an adult, or a representative designated pursuant to 42 C.F.R. 435.923.

(53) Long term service and support (LTSS)--A service provided to a qualified member in his or her home or other community-based setting necessary to allow the member to remain in the most integrated setting possible. LTSS includes services provided under the Texas State Plan as well as services available to persons who qualify for STAR+PLUS Home and Community-Based Program services or Medicaid 1915(c) waiver services. LTSS available through an MCO in STAR+PLUS, STAR Health, and STAR Kids varies by program model.
(54) Main dental home provider--See definition of "dental home" in this section.

(55) Main dentist--See definition of "dental home" in this section.

(56) Managed care--A health care delivery system or dental services delivery system in which the overall care of a patient is coordinated by or through a single provider or organization.

(57) Managed care organization (MCO)--A dental MCO or a health care MCO.

(58) Marketing--Any communication from an MCO to a client who is not enrolled with the MCO that can reasonably be interpreted as intended to influence the client's decision to enroll, not to enroll, or to disenroll from a particular MCO.

(59) Marketing materials--Materials that are produced in any medium by or on behalf of the MCO that can reasonably be interpreted as intending to market to potential members. Materials relating to the prevention, diagnosis, or treatment of a medical or dental condition are not marketing materials.

(60) MDCP--Medically Dependent Children Program. A §1915(c) waiver program that provides community-based services to assist Medicaid beneficiaries under age 21 to live in the community and avoid institutionalization.

(61) Medicaid--The medical assistance program authorized and funded pursuant to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq) and administered by HHSC.

(62) Medical Assistance Only (MAO)--A person who qualifies financially and functionally for Medicaid assistance but does not receive Supplemental Security Income (SSI) benefits, as defined in Chapters 358, 360, and 361, of this title (relating to Medicaid Eligibility for the Elderly and People with Disabilities, Medicaid Buy-In Program and Medicaid Buy-In for Children Program).

(63) Medicaid for transitioning foster care youth (MTFCY) program--The Medicaid program for young adults who aged out of the conservatorship of Texas Department of Family and Protective Services (DFPS), administered in accordance with Chapter 366, Subchapter F of this title (relating to Medicaid for Transitioning Foster Care Youth).

(64) Medical home--A PCP or specialty care provider who has accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care to members participating in an MCO contracted with HHSC.

(65) Medically necessary--

(A) For Medicaid members birth through age 20, the following Texas Health Steps services:
(i) screening, vision, dental, and hearing services; and

(ii) other health care services or dental services that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:

(I) must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole; and

(II) may include consideration of other relevant factors, such as the criteria described in subparagraphs (B)(ii) - (vii) and (C)(ii) - (vii) of this paragraph.

(B) For Medicaid members over age 20, non-behavioral health services that are:

(i) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;

(ii) provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;

(iii) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(iv) consistent with the member's medical need;

(v) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(vi) not experimental or investigative; and

(vii) not primarily for the convenience of the member or provider.

(C) For Medicaid members over age 20, behavioral health services that:

(i) are reasonable and necessary for the diagnosis or treatment of a mental health or substance use disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(ii) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
(iii) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(iv) are the most appropriate level or supply of service that can safely be provided;

(v) could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;

(vi) are not experimental or investigative; and

(vii) are not primarily for the convenience of the member or provider.

(66) Member--A person who is eligible for benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the Medicaid managed care program, and is enrolled in a Medicaid MCO.

(67) Member education program--A planned program of education:

(A) concerning access to health care services or dental services through the MCO and about specific health or dental topics;

(B) that is approved by HHSC; and

(C) that is provided to members through a variety of mechanisms that must include, at a minimum, written materials and face-to-face or audiovisual communications.

(68) Member materials--All written materials produced or authorized by the MCO and distributed to members or potential members containing information concerning the managed care program. Member materials include member ID cards, member handbooks, provider directories, and marketing materials.

(69) Non-capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is not responsible for payment.

(70) Outside regular business hours--As applied to FQHCs and rural health clinics (RHCs), means before 8 a.m. and after 5 p.m. Monday through Friday, weekends, and federal holidays.

(71) Participating MCO--An MCO that has a contract with HHSC to provide services to members.

(72) Person-Centered Care -- an approach to care that focuses on members as individuals and supports caregivers working most closely with them. It involves a continual process of listening, testing new approaches, and changing routines and organizational approaches in an effort to individualize and de-institutionalize the care environment.
73) Person-Centered Planning -- A documented service planning process that includes people chosen by the individual, is directed by the individual to the maximum extent possible, enables the individual to make choices and decisions, is timely and occurs at times and locations convenient to the individual, reflects cultural considerations of the individual, includes strategies for solving conflict or disagreement within the process, offers choices to the individual regarding the services and supports they receive and from whom, includes a method for the individual to require updates to the plan, and records alternative settings that were considered by the individual.

74) Post-stabilization care service -- A covered service, related to an emergency medical condition, that is provided after a Medicaid member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. §438.114(b) and (e) and 42 C.F.R. §422.113(c)(iii) to improve or resolve the Medicaid member's condition.

75) Primary care provider (PCP) -- A physician or other provider who has agreed with the health care MCO to provide a medical home to members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

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

77) Provider education program -- Program of education about the Medicaid managed care program and about specific health or dental care issues presented by the MCO to its providers through written materials and training events.

78) Provider network or Network -- All providers that have contracted with the MCO for the applicable managed care program.

79) Quality improvement -- A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

80) Rural Health Clinic (RHC) -- An entity that meets all of the requirements for designation as a rural health clinic under §1861(aa)(1) of the Social Security Act (42 U.S.C. §1395x(aa)(1)) and is approved for participation in the Texas Medicaid program.

81) Service area -- The counties included in any HHSC-defined service area as applicable to each MCO.

82) Significant traditional provider (STP) -- A provider identified by HHSC as having provided a significant level of care to the target population, including a DSH.

83) STAR -- The State of Texas Access Reform (STAR) managed care program that operates under a federal waiver and primarily provides, arranges for, and coordinates
preventive, primary, acute care, and pharmacy services for low-income families, children, and pregnant women.

(8482) STAR Health--The managed care program that operates under the Medicaid state plan and primarily serves:

(A) children and youth in Texas Department of Family and Protective Services (DFPS) conservatorship;

(B) young adults who voluntarily agree to continue in a foster care placement (if the state as conservator elects to place the child in managed care); and

(C) young adults who are eligible for Medicaid as a result of their former foster care status through the month of their 21st birthday.

(8583) STAR Kids--The program that operates under a federal waiver and primarily provides, arranges, and coordinates preventative, primary, acute care, and long-term services and supports to persons with disabilities under the age of 21 who qualify for Medicaid.

(8684) STAR+PLUS--The managed care program that operates under a federal waiver and primarily provides, arranges, and coordinates preventive, primary, acute care, and long-term services and supports to persons with disabilities and elderly persons age 65 and over who qualify for Medicaid by virtue of their SSI or MAO status.

(8785) STAR+PLUS Home and Community-Based Services Program--The program that provides person-centered care and services that are delivered in the home or in a community setting, as authorized through a federal waiver under §1115 of the Social Security Act, to qualified Medicaid-eligible clients who are age 21 or older, as cost-effective alternatives to institutional care in nursing facilities.

(8886) State plan--The agreement between the CMS and HHSC regarding the operation of the Texas Medicaid program, in accordance with the requirements of Title XIX of the Social Security Act.

(8987) Supplemental Security Income (SSI)--The federal cash assistance program of direct financial payments to people who are 65 years of age or older, are blind, or have a disability administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act. All persons who are certified as eligible for SSI in Texas are eligible for Medicaid. Local SSA claims representatives make SSI eligibility determinations. The transactions are forwarded to the SSA in Baltimore, which then notifies the states through the State Data Exchange (SDX).

(9088) Texas Health Steps (THSteps)--The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, described at 42 U.S.C. §1396d(r) and 42 CFR §440.40 and §§441.40 - 441.62.
(9189) Value-added service--A service provided by an MCO that is not "medical assistance," as defined by §32.003 of the Texas Human Resources Code.

§353.603 Member Participation

(a) Except as provided in subsections (b) and (d) of this section, enrollment in the STAR+PLUS program is mandatory for Medicaid recipients who meet one or more of the following criteria:

1. Have a physical or mental disability and qualify for Supplemental Security Income (SSI) benefits or for Medicaid due to low income;

2. Qualify for STAR+PLUS Home and Community-Based Waiver Services;

3. Are age 21 or older and receive Medicaid because they are in a Social Security Exclusion program and meet financial criteria for STAR+PLUS Home and Community-Based Waiver Services;

4. Are age 21 or older and are receiving SSI; and

5. Are age 21 or older and reside in a nursing facility. HHSC will enforce mandatory enrollment of this population into STAR+PLUS beginning March 1, 2015.

(b) In addition to the Medicaid recipients who must enroll in the STAR+PLUS program under subsection (a) of this section, recipients age 21 or older residing in a community-based ICF-IID or receiving services under the following Medicaid 1915(c) waivers and not enrolled in Medicare must enroll in STAR+PLUS to receive acute care services:

1. Home and Community-based Services (HCS);

2. Community Living Assistance and Support Services (CLASS);

3. Texas Home Living (TxHmL); and

4. Deaf Blind with Multiple Disabilities (DBMD).

(c) Enrollment in the STAR+PLUS program is voluntary for children under age 21 who are not in a nursing facility and who receive SSI.

1. Children residing in a community-based ICF-IID who are not enrolled in Medicare are eligible to voluntarily enroll in STAR+PLUS for acute care services;
(2) Children enrolled in the following Medicaid 1915(c) waivers who are not enrolled in Medicare are eligible to voluntarily enroll in STAR+PLUS for acute care services:

(A) HCS;

(B) CLASS;

(C) TxHmL; and

(D) DBMD.

(d) Medicaid recipients will have a choice among at least two MCOs.

(e) The following Medicaid recipients cannot participate in the STAR+PLUS program:

1. Children residing in nursing facilities;
2. Residents of state supported living centers;
3. Persons not eligible for full Medicaid benefits;
4. Children in the conservatorship of the Texas Department of Family and Protective Services; and
5. Persons enrolled in Programs of All-Inclusive Care for Elderly (PACE).

(f) Dual eligible clients.

1. Enrollment in Medicare does not affect eligibility for the STAR+PLUS program, except as specified in subsections (b) and (c)(1) and (2) of this section.
2. Dual eligible clients who participate in the STAR+PLUS program receive most acute care services through their Medicare provider, and STAR+PLUS Home and Community-Based Waiver Services through the STAR+PLUS MCO. The STAR+PLUS program does not change the way dual eligibles receive Medicare services.

(g) An individual is eligible for STAR+PLUS Home and Community-Based Waiver Services if the individual:

1. is 21 years of age or older;
2. has been determined by HHSC to be financially eligible for Medicaid;
3. is enrolled in the STAR+PLUS program;
(4) meets the level-of-care/medical necessity criteria for nursing facility placement according to applicable state and federal regulations, and as verified by an annual assessment;

(5) has an approved individual service plan with an estimated annual cost that does not exceed the applicable individual cost ceiling and service limits;

(6) chooses STAR+PLUS Home and Community-Based Waiver Services as an alternative to institutional care as described in the Code of Federal Regulations, Title 42, §441.302(d); and

(7) resides:

(A) in their own home;

(B) in a licensed assisted living facility contracted with the applicant's/member's MCO to provide STAR+PLUS Home and Community-Based Waiver Services; or

(C) in an adult foster care home contracted with the member's MCO to provide STAR+PLUS Home and Community-Based Waiver Services.

(h) An individual may apply for STAR+PLUS Home and Community-Based Waiver Services when the individual is in a nursing facility and is seeking a return to the community.

NEW RULE regarding Service Coordination to be inserted into STAR+PLUS rules (§353 Subchapter G):

(a) All STAR+PLUS members have access to service coordination. Service coordination includes:

(1) face-to-face and telephonic contacts between the member and the service coordinator;

(2) development and maintenance of a comprehensive, person-centered individual service plan (ISP);

(3) coordination to assist the member in accessing services provided by the STAR+PLUS MCO;

(4) coordination to assist the member in accessing services provided by other community entities or service providers; and

(b) STAR+PLUS members with a demonstrated need for more intensive service coordination are assigned a single, named service coordinator by the STAR+PLUS MCO. All STAR+PLUS members have access to a single, named service coordinator upon request.
§352.17 Out-of-State Medicaid Provider Eligibility

(a) This section applies only to an out-of-state Medicaid applicant or re-enrolling provider. An applicant or re-enrolling provider is considered out-of-state if:

(1) the physical address where services are or will be rendered is located outside the Texas state border and within the United States;

(2) the physical address where the services or products originate or will originate is located outside the Texas state border and within the United States when providing services, products, equipment, or supplies to a Medicaid recipient in the state of Texas; or

(3) the physical address where services are or will be rendered is located within the Texas state border, but:

   (A) the applicant or re-enrolling provider maintains all patient records, billing records, or both, outside the Texas state border; and

   (B) the applicant or re-enrolling provider is unable to produce the originals or exact copies of the patient records or billing records, or both, from the location within the Texas state border where services are rendered.

(b) An applicant or re-enrolling provider that is considered out-of-state under subsection (a) of this section is ineligible to participate in Medicaid unless HHSC or its designee approves the applicant or re-enrolling provider for enrollment on the basis of a determination that the applicant or re-enrolling provider has provided, is providing, or will provide services under one or more of the following criteria:

(1) The services are medically necessary emergency services provided to a recipient who is located outside the Texas state border, in which case the enrollment will be time-limited for an appropriate period as determined by HHSC, not to exceed one year.

(2) The services are medically necessary services provided to a recipient who is located outside the Texas state border, and in the expert opinion of the recipient's attending physician or other provider, the recipient's health would be or would have been endangered if the recipient were required to travel to Texas, in which case the enrollment will be time-limited for an appropriate period as determined by HHSC, not to exceed one year.

(3) The services are medically necessary services that are more readily available to a recipient in the state where the recipient is located, in which case the enrollment will be time-limited for an appropriate period as determined by HHSC.
(4) The services are medically necessary to a recipient who is eligible on the basis of participation in an adoption assistance or foster care program administered by the Texas Department of Family and Protective Services under Title IV-E of the Social Security Act, in which case the enrollment may be time-limited for an appropriate period as determined by HHSC.

(5) The services are medically necessary and have been prior authorized by HHSC or its designee, and documented medical justification indicating the reasons the recipient must obtain medical care outside Texas is furnished to HHSC before providing the services and before payment, in which case the enrollment may be time-limited for an appropriate period as determined by HHSC.

(6) The services are medically necessary and it is the customary or general practice of recipients in a particular locality within Texas to obtain services from the out-of-state provider, if the provider is located in the United States and within 50 miles driving distance from the Texas state border, or as otherwise demonstrated on a case-by-case basis.

(A) Enrollment under this paragraph may be time-limited for an appropriate period as determined by HHSC or its designee.

(B) An out-of-state provider does not meet the criterion in this paragraph merely on the basis of having established business relationships with one or more providers that participate in Medicaid.

(7) The services are medically necessary and the nature of the service is such that providers for this service are limited or not readily available within the state of Texas.

(8) The services are medically necessary services to one or more dually eligible recipients (i.e., recipients who are enrolled in both Medicare and Medicaid) and the out-of-state provider may be considered for reimbursement of co-payments, deductibles, and co-insurance, in which case the enrollment may be time-limited for an appropriate period as determined by HHSC, and the enrollment will be restricted to receiving reimbursement only for the Medicaid-covered portion of Medicare crossover claims.

(9) The services are provided by a pharmacy that is a distributor of a drug that is classified by the U.S. Food and Drug Administration (FDA) as a limited distribution drug.

(10) The services are medically necessary and one or more of the following exceptions for good cause exist and can be documented:

(A) Texas Medicaid enrolled providers rely on the services provided by the applicant.

(B) Applicant maintains existing agreements as a participating provider through one or more Medicaid managed care organizations (MCO) and enrollment of the applicant leads to more cost-effective delivery of Medicaid services.
(c) An out-of-state provider that applies for enrollment in Medicaid must submit documentation along with the enrollment application to demonstrate that the provider meets one or more of the criteria in subsection (b) of this section. The provider must submit any additional requested information to HHSC before enrollment may be approved.

(d) If HHSC determines that an out-of-state provider meets one or more of the criteria in subsection (b) of this section, the provider must meet all other applicable enrollment eligibility requirements, including those specified in Chapter 371 of this title (relating to Medicaid and Other Health and Human Services Fraud and Abuse Program Integrity) before enrollment may be approved.

(e) Other applicable requirements.

   (1) An out-of-state provider that is enrolled pursuant to subsections (b) through (d) of this section must follow all other applicable Medicaid participation requirements identified by HHSC for each service provided. Other applicable requirements that must be followed may include:

      (A) service benefits and limitations;

      (B) documentation procedures;

      (C) obtaining prior authorization for the service whenever required; and

      (D) claims filing deadlines as specified in §354.1003 of this title (relating to Time Limits for Submitted Claims).

   (2) Certain out-of-state providers are not entitled to utilize the extended 365-day claim filing deadline provided in §354.1003(a)(5)(H) of this title that is otherwise available to out-of-state providers, and must comply with the same claims filing deadlines that apply to in-state providers under that section. Those out-of-state providers are:

      (A) providers that are approved for enrollment under the criterion specified in subsection (b)(6) of this section, where the specific basis for approval is that the provider is located within 50 miles driving distance from the Texas state border; and

      (B) providers that are approved for enrollment under the criterion specified in subsection (b)(8) of this section regarding dually eligible recipients.

(f) An out-of-state provider that is enrolled pursuant to subsections (b) - (d) of this section must:

   (1) comply with the terms of the Medicaid provider agreement;

   (2) provide services in compliance with all applicable federal, state, and local laws and regulations related to licensure and certification in the state where the out-of-state provider is located; and
(3) comply with all state and federal laws and regulations relating to Medicaid in the state of Texas.

(g) HHSC or its designee determines the basis and amount of reimbursement for medical services provided outside Texas and within the United States in accordance with Chapter 355 of this title (relating to Reimbursement Rates).

(h) A laboratory may participate as an in-state provider under any program administered by a health and human services agency, including HHSC, that involves laboratory services, regardless of the location where any specific service is performed or where the laboratory's facilities are located if:

   (1) the laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains laboratory operations in Texas;

   (2) the laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory, individually or collectively, employ at least 1,000 persons at places of employment located in this state; and

   (3) the laboratory is otherwise qualified to provide the services under the program and is not prohibited from participating as a provider under any benefits programs administered by a health and human services agency, including HHSC, based on conduct that constitutes fraud, waste, or abuse.

§353.802 Member Participation

(a) Enrollment in the State of Texas Access Reform (STAR) program is mandatory for Medicaid recipients who meet the criteria in one or more of the following categories:

   (1) Individuals age 21 and over who are eligible for the Parents and Other Caretaker Relatives program outlined in Subchapter G of Chapter 366 of this title (relating to Medicaid for Parents and Caretaker Relatives Program).

   (2) Pregnant women receiving medical assistance with household income that meets the applicable income limits specified in Subchapter C of Chapter 366 of this title (relating to Pregnant Women's Medicaid).

   (3) Newborns receiving medical assistance--Children through 12 months of age with household income equal to or less than the FPL level specified in Subchapter E of Chapter 366 of this title (relating to Children's Medicaid) or born to Medicaid-eligible mothers.

   (4) Children receiving medical assistance age 13 months through the month of his or her 18th birthday with household income equal to or less than the FPL specified in Subchapter E of Chapter 366 of this title.
(5) FFCC members age 21 through the month of his or her 26th birthday.

(6) Children receiving medical assistance through the Department of Family and Protective Services adoption assistance or permanency care assistance program as described in 40 TAC 700 Subchapter H and 40 TAC 700 Subchapter J

(b) FFCC STAR Health members ages 18 through 20 may choose to transfer to the STAR program and remain enrolled through the month of his or her 26th birthday.

(c) MTFCY STAR Health members may transfer to the STAR program.

§353.608 Minimum Payment Amounts to Qualified Nursing Facilities

(a) Introduction. This section establishes minimum payment amounts for certain non-state government-owned nursing facility providers participating in the STAR+PLUS Program, or other Medicaid managed care programs offering nursing facility services, and the conditions for receipt of these amounts.

(b) Definitions.

(1) Calculation Period--A month used to calculate the Minimum Payment Amount. There are six calculation periods in Eligibility Period One and twelve calculation periods in Eligibility Period Two.

(2) CHOW Application--An application filed with the Department of Aging and Disability Services for a nursing facility change of ownership.

(3) Clean Claim--A claim submitted by a provider for health care services rendered to an enrollee with the data necessary for the managed care organization to adjudicate and accurately report the claim. Claims for Nursing Facility Unit Rate services that meet the Department of Aging and Disability Services' criteria for clean claims submission are considered Clean Claims. Additional information regarding Department of Aging and Disability Services' criteria for clean claims submission is included in HHSC's Uniform Managed Care Manual, which is available on HHSC's website.

(4) DADS--The Texas Department of Aging and Disability Services.

(5) Eligibility Period--A period of time for which a Qualified Nursing Facility may receive the Minimum Payment Amounts described in this section.

(6) Eligibility Period One--The first period of time for which a Qualified Nursing Facility may receive the Minimum Payment Amounts described in this section, covering dates of service from the later of March 1, 2015, or the date on which nursing facility services become managed care services, to August 31, 2015.
(7) Eligibility Period Two--The second period of time for which a Qualified Nursing Facility may receive the Minimum Payment Amounts described in this section, covering dates of service from September 1, 2015, to August 31, 2016.

(8) Eligibility Period Two-A--The third period of time for which a Qualified Nursing Facility may receive the Minimum Payment Amounts described in this section, covering dates of service from December 1, 2015, to August 31, 2016.

(9) Eligibility Period Three--The fourth period of time for which a Qualified Nursing Facility may receive the Minimum Payment Amounts described in this section, covering dates of service from September 1, 2016, to February 28, 2017.

(10) First Payment--The payment made in the ordinary course of business by MCOs to Qualified Nursing Facilities for the provision of covered services to Medicaid recipients.

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

(12) Intergovernmental transfer (IGT)--A transfer of public funds from a non-state governmental entity to HHSC.

(13) IGT Responsibility--The IGT owed by a non-state governmental entity, as determined by HHSC, for funding the non-federal share of the increase in the payments to the MCOs due to the Minimum Payment Amount program.

(14) MCO--A Medicaid managed care organization contracted with HHSC to provide nursing facility services to Medicaid recipients.

(15) Minimum Payment Amount--The minimum payment amount for a Qualified Nursing Facility, as calculated under subsection (d) of this section.

(16) Network Nursing Facility--A nursing facility that has a contract with an MCO for the delivery of Medicaid covered benefits to the MCO's enrollees.

(17) Non-state Governmental Entity--A hospital authority, hospital district, health district, city or county.

(18) Non-state Government-owned Nursing Facility--A network nursing facility where a non-state governmental entity holds the license and is a party to the nursing facility's Medicaid provider enrollment agreement with the state.

(19) Nursing Facility Add-on Services--The types of services that are provided in the nursing facility setting by a provider, but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, and augmentative communication devices, ventilator care, and tracheostomy care.
(20) Nursing Facility Unit Rate--The types of services included in the DADS daily rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements as described in §355.308 of this title (relating to Direct Care Staff Rate Component), and professional and general liability insurance. Nursing Facility Unit Rates exclude Nursing Facility Add-on Services.

(21) Qualified Nursing Facility--A Non-state Government-Owned Network Nursing Facility that meets the eligibility requirements described in subsection (e) of this section.

(22) Public Funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a non-state governmental entity that holds the license and is party to the Medicaid provider enrollment agreement with the state. 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.

(23) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform as defined and established under Chapter 354, Subchapter D of this title (relating to Texas Healthcare Transformation and Quality Improvement Program).

(24) RUG--For the purpose of calculations described in subsection (d)(1) of this section, a resource utilization group under Medicare Part A as established by the Centers for Medicare & Medicaid Services (CMS). For the purpose of calculations described in subsection (d)(2) of this section, a resource utilization group under the RUG-III 34 group classification system, Version 5.20, index maximizing, as established by the state and CMS.

(25) Second Payment--The amount a Qualified Nursing Facility can receive that is equal to the Minimum Payment Amount less adjustments to that amount, as described in subsection (d) of this section.

(c) Payment of Minimum Payment Amount to Qualified Nursing Facilities.

(1) An MCO must pay a Qualified Nursing Facility at or above the Minimum Payment Amount in two installment payments for a Calculation Period, using the calculation methodology described in subsection (d) of this section.

(A) The MCO must make the First Payment no later than ten calendar days after a Qualified Nursing Facility or its agent submits a Clean Claim for a Nursing Facility Unit Rate to the HHSC-designated portal or the MCO's portal, whichever occurs first. The MCO will make the First Payment for the Nursing Facility Unit Rate at or above the prevailing rate established by HHSC for the date of service. HHSC's website includes information concerning HHSC's prevailing rates. The MCO must make the Second Payment no later than 10 calendar days after being notified of the Second Payment amount by HHSC. The Second Payment will be the difference between the Minimum Payment Amount and the adjustment to the Minimum Payment Amount, as calculated by HHSC and described in subsection (d) of this section.
(B) For purposes of illustration only, if a Qualified Nursing Facility provider files a Clean Claim for a Nursing Facility Unit Rate on March 6, 2015, the MCO must make the First Payment no later than March 16, 2015, and the Second Payment no later than 10 calendar days after being notified of the Second Payment amount by HHSC.

(2) HHSC will provide each MCO with a list of its Qualified Nursing Facilities for each Calculation Period as well as the Second Payment amount, as calculated by HHSC and described in subsection (d) of this section, associated with the MCO's members for each of its Qualified Nursing Facilities.

(d) Calculation of the Second Payment. HHSC will calculate the Second Payment for each Qualified Nursing Facility using the methodology detailed in this subsection. If a Qualified Nursing Facility is contracted with more than one MCO, HHSC will calculate a separate Second Payment for each MCO with which the Qualified Nursing Facility is contracted.

(1) Calculate the Minimum Payment Amount. The Minimum Payment Amount is made up of multiple subsidiary amounts. There is a subsidiary amount for each RUG.

   (A) To determine the subsidiary amount for a particular RUG, use the formula:
   Subsidiary Amount = Days of Service x Medicare Rate, where:

   (i) "Days of Service" is the total Medicaid days of service for a particular RUG for clean claims for services that were provided during the Calculation Period; and

   (ii) "Medicare Rate" is the Medicare skilled nursing facility payment rate for the RUG in effect on the date of service.

   (B) The Minimum Payment Amount is equal to the sum of all subsidiary amounts calculated in accordance with subparagraph (A) of this paragraph.

(2) Calculate the Adjustment to the Minimum Payment Amount. The adjustment to the Minimum Payment Amount is equal to the sum of all adjustments for each RUG. The adjustment to the Minimum Payment Amount is determined as follows:

   (A) First, determine the amount of the First Payment to the nursing facility using the formula: First Payment = Days of Service x MCO Rate, where:

   (i) "Days of Service" is the total Medicaid days of service for a particular RUG for clean claims for services that were provided during the Calculation Period; and

   (ii) "MCO Rate" is the rate paid by the MCO for the particular RUG.

   (B) Second, sum the result in subparagraph (A) of this paragraph for each RUG.
(C) Third, add or subtract, as necessary, the amount of payment adjustments to Nursing Facility Unit Rate claims for services that were provided during the Calculation Period from the result in subparagraph (B) of this paragraph.

(D) Fourth, determine the amount related to the Nursing Facility Add-on Services using the formula: Nursing Facility Add-on Amount = Days of Service \times \text{Per Diem}, where:

(i) "Days of Service" equals the number used in subparagraph (A)(i) of this paragraph; and

(ii) "Per Diem" is an estimate, as determined by HHSC, of the weighted average per diem payment amount for Nursing Facility Add-on Services provided to Medicaid recipients in Qualified Nursing Facilities.

(I) For Eligibility Period One, the per diem will equal $3.48.

(II) For Eligibility Period Two, the per diem will equal $3.48 plus medical inflation between the mid-point of Eligibility Period One and the mid-point of Eligibility Period Two, as determined by HHSC.

(III) For Eligibility Period Two-A, the per diem will equal $3.48 plus medical inflation between the mid-point of Eligibility Period One and the mid-point of Eligibility Period Two-A, as determined by HHSC.

(IV) For Eligibility Period Three, the per diem will equal $3.48 plus medical inflation between the mid-point of Eligibility Period One and the mid-point of Eligibility Period Three, as determined by HHSC.

(E) Fifth, sum the result in subparagraph (D) of this paragraph for each RUG.

(F) Sixth, determine the adjustment to the Minimum Payment Amount by subtracting the result from subparagraph (E) of this paragraph from the result from subparagraph (C) of this paragraph.

(3) Calculate the Second Payment. To determine the Second Payment, subtract the adjustment to the Minimum Payment Amount described in paragraph (2)(F) of this subsection from the Minimum Payment Amount described in paragraph (1) of this subsection.

(e) Eligibility for Receipt of Minimum Payment Amounts.

(1) A nursing facility is eligible to receive the Minimum Payment Amounts described in this section if it complies with the requirements described in this subsection for each Eligibility Period.

(2) Eligibility Period One. A nursing facility is eligible to receive Minimum Payment Amounts for Eligibility Period One if it meets the following requirements:
(A) The nursing facility must be a Non-state Government-owned Nursing Facility with a Medicaid contract effective date of October 1, 2014, or earlier. HHSC will finalize its list of eligible facilities on November 1, 2014. A facility may only be eligible if its contract is assigned by DADS to a non-state government entity by October 31, 2014, with an effective date of October 1, 2014, or earlier.

(B) The Non-state Governmental Entity that owns the nursing facility must have entered into an IGT Responsibility agreement with HHSC by November 3, 2014. The IGT Responsibility agreement will cover the estimated IGT Responsibility for the nursing facility for the Eligibility Period.

(C) The Non-state Governmental Entity that owns the nursing facility must certify the following facts on a form prescribed by HHSC and the form must be received by HHSC by November 3, 2014.

(i) That it is a Non-state Government-owned Nursing Facility where a Non-state Governmental Entity holds the license and is party to the facility's Medicaid contract.

(ii) That all funds transferred to HHSC via IGT for use as the state share of payments are Public Funds.

(iii) That no part of any payment made under the Minimum Payment Amount program under this section will be used to pay a contingent fee, consulting fee, or legal fee associated with the nursing facility's receipt of the Minimum Payment Amount funds.

(3) Eligibility Period Two. A nursing facility is eligible to receive the Minimum Payment Amounts for Eligibility Period Two if it has met the following requirements:

(A) The nursing facility must be a Non-state Government-owned Nursing Facility with a Medicaid contract effective date of March 1, 2015, or earlier. HHSC will finalize its list of eligible facilities on March 1, 2015. A facility may only be eligible if its contract is assigned by DADS to a non-state government entity by February 28, 2015, with an effective date of March 1, 2015, or earlier.

(B) The Non-state Governmental Entity that owns the nursing facility must have entered into an IGT Responsibility agreement with HHSC by February 28, 2015. The IGT Responsibility agreement will cover the estimated IGT Responsibility for the nursing facility for the Eligibility Period.

(C) The Non-state Governmental Entity that owns the nursing facility must certify the following facts on a form prescribed by HHSC and the form must be received by HHSC by February 28, 2014.

(i) That it is a Non-state Government-owned Nursing Facility where a Non-state Governmental Entity holds the license and is party to the facility's Medicaid contract.
(ii) That all funds transferred to HHSC via IGT for use as the state share of payments are Public Funds.

(iii) That no part of any payment made under the Minimum Payment Amount program under this section will be used to pay a contingent fee, consulting fee, or legal fee associated with the nursing facility's receipt of the Minimum Payment Amount funds.

(D) The Non-state Governmental Entity that owns the nursing facility must submit to HHSC, upon demand, copies of any contracts it has with third parties that reference the administration of, or payments from, the Minimum Payment Amount program.

(4) Eligibility Period Two-A. A nursing facility is eligible to receive the Minimum Payment Amounts for Eligibility Period Two-A if it has met the following requirements:

(A) The nursing facility must not be eligible to receive the Minimum Payment Amounts for Eligibility Period Two.

(B) The nursing facility must be a Non-state Government-owned Nursing Facility with a Medicaid contract effective date of June 1, 2015, or earlier. HHSC will finalize its list of eligible facilities on June 1, 2015. A facility may only be eligible if its contract is assigned by DADS to a non-state government entity by May 31, 2015, with an effective date of June 1, 2015, or earlier.

(C) The nursing facility must have given DADS written notice of the change of ownership on or before February 1, 2015, but have not qualified for Eligibility Period Two because its contract was not assigned by DADS to a non-state government entity by February 28, 2015.

(D) DADS must have received all required documents pertaining to the change of ownership (i.e., DADS must have a complete application for a change of ownership license as described under 40 TAC §19.201(b) (relating to Criteria for Licensing)) by April 15, 2015.

(E) The Non-state Governmental Entity that owns the nursing facility must have entered into an IGT Responsibility agreement with HHSC by May 31, 2015. The IGT Responsibility agreement must cover the estimated IGT Responsibility for the nursing facility for the Eligibility Period.

(F) The Non-state Governmental Entity that owns the nursing facility must certify the following facts on a form prescribed by HHSC and the form must be received by HHSC by May 31, 2015:

(i) that it is a Non-state Government-owned Nursing Facility where a Non-state Governmental Entity holds the license and is party to the facility's Medicaid contract;

(ii) that all funds transferred to HHSC via IGT for use as the state share of payments are Public Funds; and
(iii) that no part of any payment made under the Minimum Payment Amount program under this section will be used to pay a contingent fee, consulting fee, or legal fee associated with the nursing facility's receipt of the Minimum Payment Amount funds.

(G) The Non-state Governmental Entity that owns the nursing facility must submit to HHSC, upon demand, copies of any contracts it has with third parties that reference the administration of, or payments from, the Minimum Payment Amount program.

(5) Eligibility Period Three. A nursing facility is eligible to receive the Minimum Payment Amounts for Eligibility Period Three if it has met the following requirements:

(A) The nursing facility was eligible to receive the Minimum Payment Amounts for Eligibility Period Two or Eligibility Period Two-A.

(B) The Non-state Governmental Entity that owns the nursing facility must have entered into an IGT Responsibility agreement with HHSC by a date determined by HHSC. The IGT Responsibility agreement must cover the estimated IGT Responsibility for the nursing facility for the Eligibility Period.

(C) The Non-state Governmental Entity that owns the nursing facility must certify the following facts on a form prescribed by HHSC and the form must be received by HHSC by a date determined by HHSC:

(i) that it is a Non-state Government-owned Nursing Facility where a Non-state Governmental Entity holds the license and is party to the facility's Medicaid contract;

(ii) that all funds transferred to HHSC via IGT for use as the state share of payments are Public Funds; and

(iii) that no part of any payment made under the Minimum Payment Amount program under this section will be used to pay a contingent fee, consulting fee, or legal fee associated with the nursing facility's receipt of the Minimum Payment Amount funds.

(D) The Non-state Governmental Entity that owns the nursing facility must submit to HHSC, upon demand, copies of any contracts it has with third parties that reference the administration of, or payments from, the Minimum Payment Amount program.

(6) Geographic Proximity to Nursing Facility.

(A) For eligibility period one, any nursing facility with a CHOW Application approved by DADS with an effective date on or after October 1, 2014, must be located in the same Regional Healthcare Partnership (RHP) as the Non-state Governmental Entity taking ownership of the nursing facility.

(B) For eligibility periods two, two-A, and three, any nursing facility with a CHOW Application approved by DADS with an effective date on or after October 1, 2014, must be
located in the same RHP as, or within 150 miles of, the Non-state Governmental Entity taking ownership of the nursing facility.

(f) Claims Filing Deadline. A Qualified Nursing Facility must file a Clean Claim for a Nursing Facility Unit Rate no later than 60 calendar days after the end of the Calculation Period within which the service is provided for the claim to qualify for the Minimum Payment Amount described in this section. The MCO must pay a Clean Claim that is filed after this deadline but within 365 calendar days of the date of service, at the standard rate established in the network provider agreement for Nursing Facility Unit Services; however, claims filed after the 60 deadline will not be incorporated in the calculation of the Minimum Payment Amount.

(g) IGT Responsibility.

(1) Timing. HHSC will determine IGT responsibilities prior to the first day of the Eligibility Period.

(2) Aggregate IGT Responsibility. The aggregate IGT responsibility for all Qualified Nursing Facilities for an Eligibility Period will be equal to the non-federal share of the increase in the MCOs’ capitation rates due to the Minimum Payment Amount program multiplied by the estimated number of member months for which the MCOs will receive the capitation rate during the eligibility period multiplied by 1.1.

(3) Allocation of Aggregate IGT Responsibility to Individual Nursing Facilities. HHSC will allocate the aggregate IGT responsibility to each qualified nursing facility based on the percentage of the total increase in the MCOs’ capitation rates due to the Minimum Payment Amount program associated with the nursing facility in the base period data used to develop the capitation rates.

(4) Reconciliation. HHSC will complete the reconciliation in two parts.

(A) The first reconciliation will occur no later than 120 days after the end of the eligibility period.

(i) HHSC will compare the amount transferred by the Non-state Governmental Entity to HHSC for the eligibility period to the non-federal amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity.

(ii) The calculation of the non-federal amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity will be the same as the calculation of allocated aggregate IGT responsibility to all Qualified Nursing Facilities owned by the Non-state Governmental Entity as described in paragraphs (2) and (3) of this subsection with two exceptions:
"Member months" will be revised to reflect actual known member months for the eligibility period. The revision will be conducted no sooner than the day after the last day of the eligibility period and no later than 120 days after the end of the eligibility period.

The "Aggregate IGT Responsibility" described in paragraph (2) of this subsection will be equal to the non-federal share of the increase in the MCO's capitation rates due to the Minimum Payment Amount program multiplied by the revised member months. The calculation will not include the additional ten percent included in the calculation of the original aggregate IGT responsibility.

No other changes will be made to the calculation of the allocated aggregate IGT responsibility and no other data points included in the calculation will be updated for purposes of this reconciliation.

If the amount transferred by the Non-state Governmental Entity exceeds the non-federal amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity, HHSC will refund the excess amount to the Non-state Governmental Entity, less two percent of the amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity.

If the amount transferred by the Non-state Governmental Entity is less than the non-federal amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity, HHSC will notify the Non-state Governmental Entity of the amount of the shortfall and of a deadline for the Non-state Governmental Entity to transfer the shortfall plus two percent of the amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity.

For Eligibility Period Three only, HHSC may complete interim reconciliations between February 28, 2017, and February 28, 2019, as updated enrollment data for the Program Period, as reflected in adjusted member months, becomes available. HHSC will follow the process described in subparagraph (A) of this paragraph for such interim reconciliations.

The second reconciliation will occur no later than 25 months after the end of the eligibility period.

HHSC will compare the amount transferred by the Non-state Governmental Entity to HHSC for the eligibility period to the non-federal amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity.

The calculation of the non-federal amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity will be the same as the calculation of allocated aggregate IGT responsibility to all Qualified Nursing Facilities owned by the Non-state Governmental Entity as described in subparagraph (A) of this
paragraph except that member months will be revised to reflect updated actual known member months for the eligibility period. The revision will be conducted sometime during the 25th month after the end of the eligibility period.

(iii) If the amount transferred by the Non-state Governmental Entity exceeds the non-federal amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity, HHSC will refund the excess amount to the Non-state Governmental Entity.

(iv) If the amount transferred by the Non-state Governmental Entity is less than the non-federal amount expended during the eligibility period by HHSC for all Qualified Nursing Facilities owned by the Non-state Governmental Entity, HHSC will notify the Non-state Governmental Entity of the amount of the shortfall and of a deadline for the Non-state Governmental Entity to transfer the shortfall.

(D) If the Non-state Governmental Entity does not timely complete the transfer described in subparagraph (A), (B), or (C) of this paragraph, HHSC may:

(i) determine that all nursing facilities owned by the Non-state Governmental Entity are ineligible to receive the Minimum Payment Amount for future eligibility periods;

(ii) withhold any or all future Medicaid payments from the Non-state Governmental Entity until HHSC has recovered an amount equal to the shortfall; and

(iii) retain any funds that would normally be returned to the Non-state Governmental Entity as part of the reconciliation process.

(5) All IGT calculations are solely at the discretion of HHSC and are not open to desk review or appeal.

(h) Changes of Ownership. If a Qualified Nursing Facility changes ownership to another non-state government entity during either of the eligibility periods described in subsection (e) of this section, then the data used for the calculations described in subsection (d) of this section will include data from the facility for the entire Calculation Period, including data relating to payments for days of service provided under the prior owner.

(i) Recoupment.

(1) If payments under this section result in an overpayment to a nursing facility, or in the event of a disallowance by CMS of federal participation related to a nursing facility's receipt of or use of payment amounts authorized under subsection (d) of this section, the MCO(s) may recoup an amount equivalent to the amount of the second payment amount that was overpaid or disallowed.

(2) Second payment amount payments under this section may be subject to any adjustments for payments made in error, including, without limitation, adjustments made under the Texas
Administrative Code, the Code of Federal Regulations and state and federal statutes. The MCO(s) may recoup an amount equivalent to any such adjustment from the nursing facility in question.

(3) If HHSC determines that part of any payment made under the Minimum Payment Amount program was used to pay a contingent fee, consulting fee, or legal fee associated with the nursing facility's receipt of the Minimum Payment Amount funds, the MCO(s) may recoup an amount equal to the second payment amount from the nursing facility in question.

(4) If HHSC determines that an ownership change to a Non-state Governmental Entity was based on fraudulent or misleading statements on a nursing facility CHOW application or during the CHOW process, the MCO(s) may recoup an amount equal to the second payment amount from the nursing facility in question for any eligibility period affected by the fraudulent or misleading statement.

(j) Dates the Minimum Payment Amount is available. The minimum payment requirements described in this section will only cover dates of service from the later of March 1, 2015, or the date on which nursing facility services become managed care services, to February 28, 2017.