TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

ADOPTION PREAMBLE

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §353.1305, concerning Uniform Hospital Rate Increase Program for program periods before September 1, 2021; new §353.1306, concerning Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021; and new §353.1307, concerning Quality Metrics and Required Reporting Used to Evaluate the Success of the Comprehensive Hospital Increase Reimbursement Program.

New §353.1306 and new §353.1307 are adopted with changes to the proposed text as published in the January 1, 2021, issue of the *Texas Register* (46 TexReg 13). These rules will be republished. The amendment to §353.1305 is adopted without changes to the proposed text as published in the January 1, 2021, issue of the *Texas Register* (46 TexReg 13). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

To continue incentivizing hospitals to improve access, quality, and innovation in the provision of hospital services in Year 5 of the program (i.e., September 1, 2021, through August 31, 2022) and beyond, HHSC is adopting new quality metrics, eligibility requirements and financing components for the program. HHSC is also adopting these amendments to comply with federal regulations that require directed-payment programs (DPPs) to advance goals included in the state's managed care quality strategy and to align with the ongoing efforts to transition from the Delivery System Reform Incentive Payment (DSRIP) program.

During September and October 2020, HHSC convened a workgroup of stakeholders including hospitals from all hospital classes, such as children's, rural, urban, publicly-owned, privately-owned, state-owned hospitals, as well as advocacy groups representing hospitals to assist in the design of the program structure.

The Uniform Hospital Rate Increase Program was initially implemented on December 1, 2017, and operated under Texas Administrative Code Title 1 §353.1301 and §353.1305 for the initial program year and subsequent years. Section 353.1301 is not being amended at this time. The amendment to §353.1305 will make the rule applicable to the program before September 1, 2021.

New §353.1306 and §353.1307 will apply to the program beginning on September 1, 2021, and will re-name the program the Comprehensive Hospital Increase Reimbursement Program (CHIRP), which will be comprised of the Uniform Hospital

Rate Increase Payment (UHRIP) and the Average Commercial Incentive Award (ACIA). A description of the conceptual framework of the program is as follows:

Eligibility and Enrollment

CHIRP is open to six classes of hospitals: children's hospitals, rural hospitals, state-owned hospitals that are not institutions for mental diseases (IMDs), urban hospitals, non-state-owned IMDs, and state-owned IMDs. Eligibility for hospitals will now be based upon an individual hospital application, which will allow hospitals to participate even if other hospitals within the same class do not wish to participate.

Capitation Rate Structure

CHIRP dollars will be limited by 1115 waiver budget-neutrality capacity and the amount of intergovernmental transfer (IGT) funds available for the program. The non-federal share of all CHIRP payments is funded through IGTs from sponsoring governmental entities. No general revenue is available to support CHIRP. The managed care organizations' (MCO) distribution of CHIRP funds to the enrolled hospitals will be based on the hospital's actual utilization as a uniform percentage increase. CHIRP IGTs for a specific capitation rate period will be due to HHSC approximately three months prior to the beginning of the rate period to allow HHSC's actuaries certainty as to the amount of funding to be incorporated into the capitation rates for CHIRP. The amount of the capitation will be determined by the amount of the non-federal share available for the program.

CHIRP funds will be paid through two components of the managed care per member per month (PMPM) capitation rates. Each component's value will be determined as a percentage of the amount of funding available for the CHIRP program.

Capitation Rate Components

The UHRIP Component will be equal to a percentage of the estimated difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services (Medicare gap) on a per class basis. UHRIP payments will be paid as a uniform rate increase per class within a service delivery area (SDA) and will be distributed based upon actual paid claims.

The ACIA Component will be equal to a percentage of the difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid for the same services (ACR gap) less payments received under UHRIP. ACIA payments will be paid as a uniform rate increase per class within a service delivery area (SDA) and will be distributed based upon actual paid claims.

Quality Evaluation

For each program period, HHSC will specify the performance requirements that will be associated with the designated quality metric that is expected to advance at least one of the goals and objectives in the managed care quality strategy. Achievement of the performance requirements will be used to evaluate the degree to which the program advances at least one of the goals and objectives that are incentivized by the CHIRP payments.

HHSC will publish notice of the proposed metrics and their associated performance requirements no later than January 31 preceding the first month of the program period. Final quality metrics and performance requirements will be provided on HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period.

COMMENTS

The 31-day comment period ended February 1, 2021.

During this period, HHSC received comments regarding the proposed rules from forty-seven (47) commenters: Acadia Healthcare; Adelanto HealthCare Ventures, LLC; Amerigroup Texas, Inc; Ascension; Baylor Scott & White Health; Brazos County; Cameron County Healthcare Funding District; Children's Hospital Association of Texas (CHAT); CHRISTUS Health; Community First Health Plans; Community Health Services; Doctors Hospital at Renaissance, Ltd. (DHR Health); Gjerset & Lorenz, LLP; Guadalupe Regional Medical Center; Harris Health System; HCA Healthcare; Hendrick Medical Center; Hidalgo County; JPS Health Network; LifePoint Health; McLennan County Indigent Health Care; Midland Memorial Hospital; Memorial Hermann Health System; Mitchell County Hospital; Oceans Healthcare; Rolling Plains Memorial Hospital; Signature Healthcare Services; Springstone; St. Luke's Health; SUN Behavioral Health; Teaching Hospitals of Texas (THOT); Tenet Healthcare; Texas Association of Community Health Plans; Texas Association of Health Plans; Texas Association of Voluntary Hospitals (TAVH); Texas Children's Hospital; Texas Essential Healthcare Partnerships (TEHP); Texas Health Resources; Texas Hospital Association (THA); Texas Organization of Rural & Community Hospitals (TORCH); Texas Scottish Rite Hospital; Travis County Healthcare District, d/b/a Central Health; United Regional Health Care System; University Health; University Medical Center of El Paso; Webb County; Wilson N. Jones Regional Medical Center

A summary of the comments received and HHSC's responses to the comments follow.

Participation Requirements

Comment: One commenter was concerned that since many rural hospitals did not respond to the Average Commercial Rate Survey that it will hurt them. The commenter suggested a formal application process to address the 2022 year that includes them (and the rate opportunity that some missed).

Response: No changes were made in response to this comment. The average commercial data was collected to model what the CHIRP program payments might look like, but there will be an official enrollment period to collect applications and data for state fiscal year 2022. All hospitals will have the opportunity to submit average commercial data during the official enrollment process.

Comment: One commenter expressed support for the application process and the allowance of participation in the programs by less than the entire class.

Response: HHSC appreciates the support. No changes were made in response to this comment.

Comment: One commenter asked if hospitals who have not previously participated in UHRIP can apply to the CHIRP Program.

Response: No changes were made in response to this comment. Yes, hospitals can apply to the program that have not previously participated in UHRIP if they meet the conditions of participation and other program requirements.

Comment: One commenter asked whether CHIRP allows a hospital to opt into either the UHRIP or ACIA component or if the option is available only for ACIA for hospitals that apply for CHIRP.

Response: Providers can choose to participate in UHRIP without participating in ACIA, they can participate in both UHRIP and ACIA, or they can choose to not participate in either component. The option is not available to participate in ACIA without participating in UHRIP. In response to this comment, HHSC revised §353.1306(c)(1)(A) to clarify that ACIA is only available to hospitals that first choose to participate in UHRIP.

Comment: Two commenters were concerned that proposed §353.1306(c)(2) would effectively make a hospital ineligible to participate in CHIRP if it has used revenue from CHIRP payments to pay a consultant or lawyer fees for assistance with CHIRP, regardless of the underlying fee structure. The commenters added that while it appears that consulting fees and legal fees that are paid from a hospital's non-CHIRP revenue sources would not cause any issues under proposed §353.1306(c)(2), isolating revenue from CHIRP payments in such a way to ensure that such revenue is not utilized for consulting and legal services related to CHIRP may be administratively difficult for many hospitals. The commenters urged HHSC to reconsider the proposed participation requirement by revising or removing the proposed requirement.

Response: HHSC agrees with the commenters that the rule language should be refined to more clearly prohibit contingency fees for services that are based solely on the amount of the hospital's CHIRP revenue. HHSC agrees that hospitals may utilize consultants, advisors, or legal counsel for a variety of reasons. HHSC has amended §353.1306(c)(2) to specify that no part of any CHIRP payment will be used to pay a contingent fee nor may the entity's agreement with the hospital use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program including the hospital's receipt of CHIRP funds.

Comment: Multiple commenters expressed concern with the proposed condition in §353.1306(c)(3) that "[t]he entity that owns the hospital must submit to HHSC, upon demand, copies of contracts it has with third parties that reference the administration of, or payments from, CHIRP." The commenters said the request for contract disclosures is overly broad and risks putting HHSC in the business of policing entirely private agreements that do not involve a governmental entity or state action. The commenters further said that the broad disclosure request creates confidentiality concerns for providers and risks forcing the disclosure of commercially sensitive information. Commenters urged HHSC to remove the proposed condition or at a minimum to revise the broad language.

Response: HHSC agrees with the commenter that HHSC does not wish to impose significant administrative burdens or to infringe upon third parties' relationships to which a governmental entity is not a party. HHSC's intent of the proposed language was specific to instances where a change of ownership has occurred that would impact the eligibility of the provider. HHSC made a change to §353.1306(c)(3) to clarify the applicability of this provision.

Comment: Two commenters asked if HHSC will need to collect additional data from hospitals in order to support the proposed pool size announced for CHIRP. If so, the commenters requested that HHSC provide at least 30 days of lead time to complete the analysis to ensure that they have time to provide the most accurate and complete information.

Response: No changes were made in response to this comment. HHSC will collect additional data from hospitals wanting to participate in ACIA during the CHIRP enrollment period, as well as general hospital information like hospital name and national provider identification number. Enrollment will be open for no less than 21 calendar days. At this time, HHSC is not extending the enrollment period.

Comment: Two commenters asked HHSC to clarify if hospitals will submit applications to participate in CHIRP on a twelve-month or six-month basis. If applications are every twelve months, aside from the proposed rules' reference to permitting SDAs to join at the halfway point of the state fiscal year, the commenters asked if there are other circumstances (e.g., new hospital opens or hospital undergoes change in ownership) where HHSC would permit a provider to

submit an application and begin participating in CHIRP during a program period before the next twelve-month application opportunity.

Response: Applications are submitted on a 12-month basis. There are no circumstances where HHSC would permit a provider to submit an application and begin participating in CHIRP before the next 12-month application opportunity. HHSC revised §353.1306(b)(7) to clarify this requirement.

Comment: One commenter appreciated the proposed rule including an "opt-in" procedure in which the hospital must select whether it will participate in the optional program components.

Response: HHSC appreciates the support. No changes were made in response to this comment.

Classes of Participating Hospitals

Comment: One commenter asked HHSC to confirm the hospital class for "private rural hospitals" and "private urban hospitals." Two other commenters noted that the proposed rules' definitions do not include urban private hospitals as a participating class for CHIRP. These commenters said they believe this was a clerical oversight and that HHSC will revise the rules upon adoption to include both private and public urban hospitals.

Response: Private rural hospitals fall within the "rural hospital" classification for CHIRP. In proposed §353.1306(d)(1)(D), HHSC included "urban public hospitals" as a class. The class should have been "urban hospitals," as it was correctly described in the proposed preamble, to describe both private and public urban hospitals in a single class. Subsection (d)(1)(D) was revised to change the class to "urban hospitals."

Comment: One commenter asked if a Sole Community Hospital and Critical Access Hospital in an Metropolitan Statistical Area (MSA) are classified as "urban hospitals" or "rural hospitals" for UHRIP. The commenter said that it appears urban, per their reading, but requested confirmation.

Response: No changes were made in response to this comment. There may be instances where a Sole Community Hospital (SCH) or Critical Access Hospital (CAH) in a MSA can be considered rural. Per the definition included in the rule, a hospital that is a SCH or CAH or Rural Referral Center (RRC) is considered rural if it is not located in an MSA, or if it has fewer than 100 beds, is a SCH, CAH, or RRC and is located in an MSA.

Comment: Multiple commenters expressed concern with HHSC's proposal to change the classes of participating hospitals from eight classes (in UHRIP) to six classes (in CHIRP). Specific concerns were noted about the proposal to combine rural private hospitals and rural public hospitals into a single class and the proposal to combine urban public hospitals and urban private hospitals into a single class. The

commenters pointed to differences between the hospitals (e.g., Medicare gap is larger for private hospitals than public, rural hospitals are not all paid the same) and said that combining them into the respective classes will result in reduced payments for some of the hospitals. Some of the commenters said accommodations should be made, either in CHIRP or a related supplemental payment program to balance the inequity.

Response: No changes were made in response to this comment. HHSC has decided to collapse the class structure into the hospital inpatient rate classes to more closely align with established classes in the Medicaid state plan. Although at this time HHSC is not planning to modify related supplemental programs based on CHIRP, the CHIRP payments will continue to be offset from the State Payment Caps for the Disproportionate Share Hospital program which may also affect the distribution of Uncompensated Care payments.

Comment: One commenter asked if there are documented definitions for the provider class criteria determining component eligibility.

Response: The provider class criteria can be found in 1 TAC §355.8052 for most hospital classes. To further clarify what constitutes an IMD hospital, HHSC has revised the definition at §353.1306(b)(4) to clarify that IMD hospitals are reimbursed as freestanding psychiatric facilities under 1 TAC §355.8060.

Comment: One commenter asked if a hospital is classified as non-urban public for UHRIP purposes, how will they be classified for CHIRP.

Response: No changes were made in response to this comment. The hospital will fall under the class “urban hospital” in CHIRP.

Comment: One commenter expressed support for HHSC's proposal to consolidate hospitals classes from eight to six. The commenter was previously concerned that the proposal would disproportionately shift funding from private urban hospitals to public urban hospitals but said that HHSC's modeling addressed this issue and is now supportive of the proposal.

Response: HHSC appreciates the support. No changes were made in response to this comment.

Services subject to rate increase

Comment: Multiple commenters expressed their appreciation for the inclusion of private IMDs in CHIRP but asked HHSC to reconsider the decision to exclude the adult population from the scope of the CHIRP rate increase. The commenters said the availability of a CHIRP rate increase for adult patients would allow IMDs to provide better access to care for this underserved population and ease the demand for care in state psychiatric hospitals.

Another commenter noted that the Centers for Medicare & Medicaid Services' (CMS) 2016 Medicaid Managed Care Final Rule allows states to receive federal Medicaid funds for capitation payments on behalf of nonelderly adults who receive inpatient psychiatric services in an IMD with a cap of 15 inpatient days during a given month. The commenter said that Texas currently receives these funds, and both the 1115 Waiver Special Terms & Conditions and the Uniform Managed Care Terms & Conditions allow MCOs to pay IMDs for providing inpatient psychiatric services to their enrollees aged 21 through 64 in lieu of an acute care hospital inpatient setting. This commenter requested HHSC amend §353.1306(f)(2) to align the proposed rules with current payment practice and policy.

Response: No changes were made in response to these comments. There are certain federal regulations, including actuarial requirements, related to IMDs providing services to individuals ages 21 through 64. These requirements make it difficult to provide a CHIRP rate increase for this population.

Comment: One commenter said the language in proposed §353.1306(f)(1) is vague and that HHSC should provide a listing of services that will be covered under CHIRP.

Response: No changes were made in response to this comment. HHSC will direct rate increases for inpatient and outpatient services.

Comment: Regarding §353.1306(f)(1), one commenter asked if MCOs will have flexibility to apply rate increases unique to the patient population seen and etiology of those patients, as the etiology varies within SDA by MCO.

Response: No changes were made in response to this comment. MCOs will only apply rate increases as directed by HHSC.

Allocation Methodology & CHIRP Capitation Rate Components

Comment: Two commenters asked for confirmation about the percentage increase hospitals will receive. One commenter asked if all hospitals in a class (e.g., urban hospitals) will receive the same UHRIP percentage regardless of SDA. The other commenter asked if all rural hospitals will receive the same UHRIP/ACIA percentage increase, regardless of region or designation (CAH or Prospective Payment System).

Response: HHSC received overwhelming comments that supported defining the hospital classes based upon SDA. As a result, HHSC modified §353.1306 to define the classes based upon inpatient rate class and SDA. All hospitals in a class will receive the same UHRIP percentage within an SDA. The ACIA percentage increase will be a unique percentage for each hospital, but the estimated payment for each hospital will be a uniform percentage of the gap (not to exceed 100 percent) less UHRIP payments. The ACIA percentage increase is calculated based on the estimated payment. Rural hospitals will receive the same UHRIP percentage regardless of designation and will receive unique percentages for ACIA that result from paying the same uniform percentage of their ACR gap less UHRIP payments.

Comment: One commenter expressed concern with the projections shown for rural hospitals in the modeling HHSC posted to its website on January 27, 2021. The commenter said that rural hospitals will come out short in the calculations due to a combination of a little better Medicaid reimbursement and a little less favorable commercial contracts (ACR). Although it is not reflected in Medicare base rates, the commenter said there are a number of rural extenders (add on payments) in the Medicare program (e.g., the low volume adjustment (LVA), bad-debt settlement) that can often account for a 20 to 30 percent increase to traditional Medicare payments for rural Texas hospitals. The commenter said that if the rural extenders could be part of the Medicare UPL gap formula, it would help soften rural harm in the transition from DSRIP to DPPs.

Response: No changes were made in response to this comment. Medicare data is from the Medicare cost reports. UPL Medicare payments are from Worksheet E Part 1 Column 2 Line 4 Total interim payments for Inpatient Part A from the Title XVIII cost report. At this time, HHSC is not making any updates to the UPL demonstration calculations, which are performed in accordance with federal requirements and instructions.

Comment: One commenter is concerned that the Network Access Improvement Program (NAIP) hospital pass through payments are included in the Medicare gap and ACR gap calculations and said it results in reduced CHIRP payments. The commenter reasoned that NAIP is substantially related to physician/faculty program support that is passed through to hospitals and that discounting hospital rates for these physician payments disadvantages affected hospitals. The commenter also added that inclusion of NAIP suggests payment gaps for affected hospitals are smaller than they really are. The commenter asked that HHSC remove NAIP payments from the gap calculations or otherwise seek adjustments and flexibility from CMS to exclude NAIP as hospital payments for purposes of allocating CHIRP payments.

Response: No changes were made in response to this comment. CMS requires that all directed payments and pass-through payments be included in the evaluation of total payment levels for hospitals. If NAIP payments are not considered during the calculation of the Medicare and ACR gap, there is a risk that total payment levels will exceed the Medicare and ACR amounts. HHSC plans to continue to offset NAIP payments in the Medicare and ACR UPL gaps for this reason.

Comment: One commenter asked HHSC to confirm their understanding of the ACIA rules. For ACIA, the intent is to have a uniform increase across all hospital ACR gaps. Example: A 50 percent ACIA increase of an ACR gap of $10 or $100 will be $5 and $50, respectively. This will mean the rate increases between hospitals and MCOs will be different to achieve 50 percent of the ACR gap for the ACIA increase after UHRIP is considered. While all providers will take the same haircut percentage, the ACIA methodology will result in hospitals in the same statewide class having different (non-uniform) final rate increase percentages after their ACIA allocation is factored in.

Response: That is correct, the percentages will vary from provider to provider in order to achieve the same percentage of the ACR gap. One clarification is that the UHRIP component will also be included in the calculation. HHSC amended §353.1306(g)(3)(B) to provide an example of how the calculation will be performed. Additionally, HHSC upon adoption of the rule has decided to define classes to include geographic boundaries, rather than on a statewide basis.

Comment: One commenter asked if there is any indication of what the increase will be to meet the performance measures.

Response: No changes were made in response to this comment. This is outside the scope of the rules. Measure performance goals are being determined through a separate process outside of these rules.

Comment: Some commenters noted that the proposed rules provide that HHSC will set the total value of UHRIP as a percentage of the estimated Medicare Upper Payment Limit (UPL) gap for each statewide hospital class but provide no details on exactly how HHSC will calculate the Medicare UPL. The commenters asked HHSC to define the UHRIP payment component more clearly and asked that HHSC provide an opportunity for hospitals to review HHSC modeling and provide input on the UPL pool sizing method.

Response: No changes were made in response to this comment. The UHRIP rate increases will be calculated using the total Medicare UPL gap of each class within an SDA compared to total encounters. The Medicaid payments used to calculate the gap exclude the Disproportionate Share Hospital (DSH), Uncompensated Care (UC), and UHRIP payments. DSH and UC payments are excluded because they cannot be easily split between inpatient and outpatient. Every hospital in a class within an SDA will have the same uniform percentage increase for UHRIP. HHSC shared initial modeling with stakeholders on January 27, 2021 and plans to release updated modeling in the future. At this time, HHSC is continuing to use the payment-to-charge methodology for the Medicare UPL test.

Comment: Two commenters noted that the proposed rules speak to calculating an average commercial rate gap statewide, and then allocating a funding allocation on a hospital-specific basis. If HHSC is unable to provide an updated CHIRP funding model, the commenters asked HHSC to provide a specific calculation example of how HHSC will calculate an individual hospital's ACIA entitlement. The commenters also asked if HHSC has confirmed with MCOs whether this is administratively possible.

Response: HHSC shared initial modeling with stakeholders on January 27, 2021 and plans to release updated modeling in the future. HHSC also revised the rule at §353.1306(g)(3) to add an example to explain the calculation of ACIA.

Comment: One commenter asked HHSC to guarantee a minimum floor on the state fiscal year 2022 CHIRP implementation for each rural hospital equal to the greater

of their state fiscal year 2021 rate increase percentage or the new total CHIRP add-on percentage HHSC calculates for state fiscal year 2022. The commenter noted the shift to inpatient hospital base rate classes and statewide calculations as reasons for this request. The commenter also referenced that during the state fiscal year 2021 implementation of UHRIP, HHSC provided hospital classes in each SDA the greater of the rate increase percentage from either (i) their new Medicare gap calculation, or (ii) the rate increase percentage in place for state fiscal year 2020.

Alternatively, the commenter asked HHSC to either retain the current hospital class definitions and SDA structure in CHIRP, or at least guarantee the rural hospitals total CHIRP add-on percentage will equal at least the median (59 percent) rate increase percentage of the various rural private and rural public hospital classes' SFY 2021 managed care hospital rate increase percentages.

Response: No changes were made in response to this comment. HHSC is not guaranteeing a minimum floor or guaranteeing a median rate for any hospital class. CHIRP has been redesigned and HHSC is not developing a methodology that is based on prior UHRIP program year payments.

Comment: One commenter agrees with HHSC’s approach to use an external benchmark to calculate uniform rate adjustments. The commenter said that using an external benchmark provides a standard to ensure that the rates are appropriate and justifiable.

Response: HHSC appreciates the support. No changes were made in response to this comment.

Comment: Some commenters asked why UHRIP is based on the Medicare gap and ACIA is based on the commercial payment rate, and if there is a significant difference between the Medicare gap and commercial payment rates. Commenters also asked if the percentage for UHRIP and ACIA will be released prior to the application.

Response: No changes were made in response to this comment. The UHRIP component is based on the Medicare gap to align with previous program years of UHRIP. Medicaid payments should be similar to Medicare and CMS requires states to demonstrate that their payments are considered reasonable compared to Medicare. ACIA is based on the average commercial reimbursement rate to allow providers to receive an amount above what Medicare pays since commercial reimbursement may be higher than Medicare. The difference between the Medicare gap and commercial payments rates will vary from provider to provider. Percentage rate increases are determined based on enrollment.

Comment: One commenter asked what necessary data providers need to submit to calculate the ACR gap. The commenter also asked what happens if providers cannot submit the data due to contracts with commercial providers.

Response: No changes were made in response to this comment. To participate in ACIA, a provider will need to submit: inpatient charges, inpatient payments, inpatient days, inpatient stays, outpatient charges, outpatient payments, and outpatient claims.

Comment: One commenter asked whether it would affect UHRIP payments if a provider does not participate in ACIA.

Response: No changes were made in response to this comment. No. If a hospital chooses not to participate in ACIA, it will not affect the calculation of their UHRIP payments. ACIA is an optional component to provide hospitals with an additional opportunity for payment. If a hospital chooses to only participate in UHRIP, they will receive the same UHRIP percentage as the other hospitals in their class.

Comment: One commenter said that the proposed CHIRP methodology adversely affects Texas' super safety net providers and public hospitals across the state. Under CHIRP, the commenter noted that these providers face significant funding reductions and have few opportunities to participate in directed payment or other transitioned programs to contribute to the state's goals under the waiver. The commenter asked that HHSC address and correct within the waiver and DSRIP transition programs, the severe inequity in funding distribution reflected in CHIRP modeling. The commenter also urged HHSC to complete modeling to evaluate the impact of the increase in CHIRP funding on the state's other supplemental payment programs and on overall Medicaid payments as a percentage of Medicaid allowable costs by hospital class under this proposed model.

Response: No changes were made in response to this comment. HHSC appreciates the contributions of all hospitals in Texas to providing care to both Medicaid clients and the uninsured. However, state-directed payments in managed care should be based upon appropriate and attainable reimbursement for the Medicaid managed care services that are delivered to Medicaid managed care beneficiaries. HHSC believes that other programs that are not beneficiary specific, such as the Disproportionate Share Hospital program and the Uncompensated Care program, should be used to provide financial support for uninsured or charity care costs.

Comment: One commenter said HHSC should continue to tailor UHRIP rate increase percentages and funding allocations by Medicaid managed care SDA. The commenter reasoned that each SDA faces unique challenges, including potential Medicaid DSH/UC entitlement offsets, and moving to a statewide structure inhibits local stakeholders from tailoring the UHRIP component in the way that is best for that community.

Response: HHSC agrees that there are regional variations and market dynamics that should be considered when establishing reimbursement rate increases under CHIRP and amended §353.1306 to define the rate classes to include geographic boundaries. However, HHSC does not agree that the class definitions under CHIRP should be defined as a result of the potential impact that may be experienced in other programs. Rather, HHSC believes that CHIRP payments should be based upon

appropriate and attainable reimbursement for the Medicaid managed care services that are delivered to Medicaid managed care beneficiaries.

Comment: Multiple commenters said that both rate increases, and the non-federal share of the program, should continue to be determined and administered by class on an SDA-by-SDA level. The commenters reasoned that Texas is a large and diverse state and that the CHIRP program should consider the very different market, demographic, and other conditions that regional providers experience. According to the commenters, sourcing and crediting IGT on a statewide level will be problematic and risks overriding local policy decisions and overburdening the very communities who rely most heavily on the Medicaid program. The commenters further noted that federal law does not prohibit consideration of regional factors in establishing classes for purposes of a uniform rate increase.

Some of the commenters noted that the proposed rule does not specify whether the IGT supporting the non-federal share will be sourced and credited at an SDA level or on a statewide level, such as by class-type statewide, but said that proposed §353.1306(d)(1), (d)(2), and (e) all appear to contemplate HHSC continuing to determine rate increases at the SDA level.

Response: HHSC agrees that there are regional variations and market dynamics that should be considered when establishing reimbursement rate increases under CHIRP and amended §353.1306 to define the rate classes to include geographic boundaries. However, HHSC affirms that transferring of IGT to HHSC is voluntary and, while HHSC may consider available funding, among other factors, when determining the size of the program, HHSC should not be and is not involved with local decisions about whether to make such a voluntary transfer. The rules for CHIRP do address the process by which HHSC will collect information about whether units of local government wish to contribute IGT towards the program and specifies dates for when the IGT is requested to be transferred. The rules do not describe the use of specific IGT for specific jurisdictions, statewide or otherwise.

Distribution of CHIRP Payments

Comment: Proposed §353.1306(g) says "The MCOs' distributions of CHIRP funds to the enrolled hospitals may be based on each hospital's performance related to the quality metrics." One commenter asked if this means that both the UHRIP and ACIA components may be conditioned on or are subject to the achievement of quality metrics or if it only applies to ACIA.

Response: No changes were made in response to this comment. The language in proposed §353.1306(g) is not mandatory. HHSC further described in subsection (h) that CHIRP payments will be distributed based upon actual utilization as a uniform rate increase. Providers will be required to adhere to the program eligibility requirements, including mandatory reporting, to remain eligible for the program, however the payments will not be based upon achievement of a specific measure.

Comment: One commenter asked if ACIA payments will be based on "pay for reporting" requirements only or if some portion of the payments will be conditioned on quality outcome measures, such as "pay for performance." The commenter also asked if this will shift over time.

Response: No changes were made in response to this comment. Per §353.1306(h), CHIRP payments will be based upon actual utilization as a uniform rate increase.

Comment: Two commenters asked if payments will be paid as a lump-sum or a rolling per claim basis like current UHRIP payments. If lump-sum, one commenter asked what the proposed timing is.

Response: No changes were made in response to this comment. Per §353.1306(h), CHIRP payments will be based upon actual utilization as a uniform rate increase.

Comment: Some commenters asked HHSC to direct MCOs to make quarterly lump sum CHIRP payments. The commenters said that as long as the lump sum payments are tied to actual utilization during the contract period, lump sum payments comply with CMS' January 8, 2021, State Medicaid Director letter provisions requiring that the payments are tied to actual services and utilization during the contract period. The commenters added that pursuing the lump-sum payment method would allow HHSC to revise the timeline for collecting the non-federal share of CHIRP funds to ease cash flow burdens on IGT entities.

Response: No changes were made in response to this comment. IGT transfers for directed-payment programs will be made semi-annually for all programs.

Comment: One commenter implored HHSC to discontinue the practice of using the MCO's claim system as an intermediary pass-through system. According to the commenter, IGT dollars are provided to MCOs' capitation merely to pass-through payments to providers and MCOs should not be a fiduciary intermediary in funding providers. The commenter said maintaining the integrity of a claim system is paramount to avoid downstream confusions. The commenter asked HHSC to replicate the Quality Incentive Payment Program (QIPP) for Nursing Facilities in a similar way for CHIRP. In QIPP, upon completion, HHSC notifies the MCOs of the eligible incentive payment for the applicable providers and the funds provided are completely autonomous of the MCO's Claims System. The commenter believes that this solution will result in HHSC saving money by eliminating MCO administrative fees and creates a simplified reconciliation process for hospitals.

Response: No changes were made in response to this comment. HHSC believes that state-directed payments that are used to advance a goal or objective in the state's quality strategy are appropriate and compliant with federal regulations and that such programs are in the best interest of the Medicaid managed care beneficiaries that receive services from the providers receiving these uniform rate increases. MCO capitation rates contemplate the administrative resources required to implement changes in relationship to state-directed payments.

Comment: One commenter asked HHSC to clarify if MCOs will distribute funds to providers. The commenter also asked what the timeframe is for payment once reporting is submitted to HHSC.

Response: No changes were made in response to this comment. HHSC will direct the MCOs to distribute funds to hospitals through its Medicaid managed care contracts. Per §353.1306(h), CHIRP payments will be distributed based upon actual utilization and be paid on a percentage increase to the contracted rate between the MCO and the hospital. The timeframes for reimbursement of claims are determined by MCO contractual requirements related to timely payment.

Determination of percentage of rate increase

Comment: Two comments requested clarification on what "hospital market dynamics within the SDA" means in proposed §353.1306(g)(1)(F).

Response: No changes were made in response to this comment. HHSC understands that there are different types of hospitals within an SDA who may contribute to serving different patients, have different levels of financial stability, or who may have different payor mixes. HHSC reserves the right to consider these factors when determining rate increases.

Comment: One commenter expressed support for HHSC including a standard benchmark such as the percentage of audited Medicaid costs that are paid by Medicaid in its considerations when determining percentages of rate increases by class. The commenter said this provides an important standard to consider different hospital classes' current shortfalls when determining future increases (as in section §353.1306(e)(2)(E)). The commenter also strongly recommended HHSC use this feature to address funding inequities.

Response: No changes were made in response to this comment. HHSC believes that the appropriate program to consider uncompensated Medicaid cost is the Disproportionate Share Hospital program, which is designed to reimburse hospitals for uncompensated costs for care provided to Medicaid beneficiaries and the uninsured.

Comment: Regarding proposed §353.1306(d)(2), one commenter asked what determination method will be used by HHSC for intra-SDA multi-class hospital rate increase determination.

Response: No changes were made in response to this comment. The cited paragraph indicates that rate increases can differ between classes, but that rates of all hospitals within individual classes are uniform. Determination method is described in 353.1306(i).

Non-federal share of CHIRP payments & Reconciliation

Comment: One commenter asked if HHSC will continue to pool IGT only at the Managed Care Service Area as it has in the past (as opposed to State-wide). The commenter further asked if IGT is short in one Managed Care Service Area, will that result in a haircut to all of the Managed Care Service Areas (in order to pay a uniform rate to each hospital classification).

Response: HHSC agrees that there are regional variations and market dynamics that should be considered when establishing reimbursement rate increases under CHIRP and amended §353.1306 to define the rate classes to include geographic boundaries. However, HHSC affirms that transferring of IGT to HHSC is voluntary and, while HHSC may consider available funding, among other factors, when determining the size of the program, HHSC should not be and is not involved with local decisions about whether to make such a voluntary transfer. The rules for CHIRP do address the process by which HHSC will collect information about whether units of local government wish to contribute IGT towards the program and specifies dates for when the IGT is requested to be transferred. The rules do not describe the use of specific IGT for specific jurisdictions, statewide or otherwise.

Comment: One commenter noted that the IGT is due three months before the capitation period begins. The commenter asked if the amount of IGT will be estimated and, if so, how the estimations will be made.

Response: No changes were made in response to this comment. Estimates for IGT will be provided in advance for hospital providers and governmental entities to coordinate their declaration of intent. Estimates are based on preliminary trend factors from actuarial analysis.

Comment: Commenters expressed concern with HHSC collecting IGTs on a statewide rather than regional basis. Commenters said that moving to a statewide pool could result in a local governmental entity supporting hospitals in another SDA that may or may not have enough IGT to fund their CHIRP payments and that this could result in a reduction in funding for their local hospitals. Some commenters said that HHSC can address the concerns by limiting funding shortages to the SDA that is unable or unwilling to provide the level of IGT needed to fund the payments. One commenter said that if HHSC is unable to retain its historical policy of pooling IGTs by SDA, HHSC should allow local governmental entities to designate the specific hospital service delivery areas their local funds are intended to support.

Response: HHSC is moving to an individual application process instead of using SDA liaisons to allow individual hospitals to choose whether they want to participate in the program even if other hospitals in their class choose not to participate. HHSC agrees that there are regional variations and market dynamics that should be considered when establishing reimbursement rate increases under CHIRP and amended §353.1306 to define the rate classes to include geographic boundaries. However, HHSC affirms that transferring of IGT to HHSC is voluntary and, while HHSC may consider available funding, among other factors, when determining the size of the program, HHSC should not be and is not involved with local decisions about whether to make such a voluntary transfer. The rules for CHIRP do address

the process by which HHSC will collect information about whether units of local government wish to contribute IGT towards the program and specify dates for when the IGT is requested to be transferred. The rules do not describe the use of specific IGT for specific jurisdictions, statewide or otherwise.

Comment: Multiple commenters are concerned with the proposed timeline at §353.1306(j)(3) for collecting the non-federal share of CHIRP payments. The commenters believe that the timeline creates the possibility (or even likelihood) that HHSC will collect the non-federal share prior to receiving pre-print and pool size approval from CMS, thus causing stress on sponsoring governmental entities.

Some of the commenters recommended HHSC split the advanced non-federal share into three-month periods, similar to the approach HHSC used for the fourth program year of UHRIP. These commenters said this approach will minimize the impact of hospital cash flow as well as the potential for refunds if the size of the program is significantly reduced. Other commenters recommended revisions to the timeline to account for potential pre-print approval timing issues.

Response: HHSC has a long-established practice of requesting IGT in semi-annual installments. HHSC will seek to receive pre-print approval as early as possible to provide both the state and units of local government certainty, but is unable to guarantee that approval will be received in that time frame. HHSC made edits to §353.1306(j) in response to this comment to ensure units of local government have adequate time to prepare for the semi-annual IGT transfer.

Comment: Commenters requested clarification on the reconciliation of IGT amounts in the event of a shortfall. Commenters said it is unclear if HHSC intends to perform the reconciliation process described in §353.1301(g) on a statewide basis or on an SDA-by-SDA basis. Two commenters said that if HHSC is unwilling to bifurcate the payment classes and IGT pooling approach, HHSC should develop an IGT reconciliation process that accounts for the local financing relationships, variances in ACIA payments, and potential regional shortages.

Response: No changes were made in response to this comment. All IGT reconciliations are described in §353.1301(g), which says reconciliation of funds are proportional to how the IGT was received.

Comment: One commenter asked if HHSC is proposing a reconciliation process that will operate in the same manner as QIPP. If payments are made on a per claim basis, the commenter said HHSC must make an assumption up front and asked how HHSC plans to work with the MCOs to deal with the reconciliation if the amount is insufficient. The commenter also asked what downside risks MCOs are expected to take on.

Response: No changes were made in response to this comment. In CHIRP, the only reconciliation process is related to the transfer of IGT and will be handled in accordance with §353.1301(g).

Comment: One commenter said they heard that neither UHRIP or ACIA components are pay for reporting but noted that it appears HHSC can recoup payment if a provider fails to report or prevent a provider from future program participation. The commenter asked HHSC to explain this distinction.

Response: Reporting quality data is a condition of participation in the program and failure to report would deem the provider ineligible to participate in the program. Pay-for-reporting ties a specific payment value to the act of reporting. If a provider failed to report in a pay-for-reporting circumstance, they could retain eligibility for the program, but not receive a payment. CMS does not permit pay-for-reporting in state-directed payment programs. HHSC made several revisions to §353.1307 in response to this comment. Subsections (c) and (d) were amended to clarify that a quality metric will be identified as a structure, process, or outcome measure and that HHSC will use reported performance of the quality metrics to evaluate the degree to which the arrangement advances at least one of the goals and objectives that are incentivized by the payments described under §353.1306(g). HHSC also deleted the references to pay-for-reporting measures and relabeled (d)(2) as subsection (e).

Quality

Comment: Two commenters requested more clarity around which portions of the program are tied to quality and in what way. One of the commenters also asked what the consequence is of hospitals failing to meet the metrics.

Response: No changes were made in response to this comment. As a condition of CMS approval of a State Directed Payment Program, HHSC must certify that the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy.

As a condition of participation in the program, hospitals will report on a standard set of quality measures as determined by a hospital's class and volume of certain Medicaid Managed Care services provided. A hospital that fails to submit the required data by deadlines communicated by HHSC will be determined to not be in compliance with program eligibility requirements and will be removed from the program. The provider may also have all funds that it received recouped. There are no redistributions of recouped funds in CHIRP and funds recouped would be retained by the MCO.

Comment: Some commenters are concerned with the short timeframe between the release of the proposed quality metrics for the program and the publication of the finalized quality metrics. Two commenters recommended moving the timeline for the notice, hearing and finalization to earlier in the fiscal year to ensure that providers have systems in place to accommodate the needed data for the selected metrics and to allow sufficient time for providers to review and provide feedback on the measures.

Response: No changes were made in response to this comment. HHSC will attempt to maximize the time period for public comment in future program years. Because of required timing of rule effectiveness, and preprint submission, HHSC declines to extend the timeframe for feedback on proposed measures and performance requirements at this time.

Comment: Some commenters recommended that HHSC make quality achievement and reporting as simple as possible and clarify how it will address any hospital's failure to meet quality requirements. The commenters suggested selecting nationally recognized measures and specifications that hospitals already report, such as those included in the Medicaid Adult or Child Core Sets or National Quality Forum core measures. The commenters also think that such measures should not require hospitals to create new reporting systems or employ additional staff to manage the reporting.

Response: No changes were made in response to this comment. A hospital that fails to submit the required data by deadlines communicated by HHSC will be determined to not be in compliance with program eligibility requirements and will be removed from the program. The provider may also have all funds that they received recouped. There are no redistributions of recouped funds in CHIRP and funds recouped would be retained by the MCO. HHSC has selected some measures that align with established federal or state measures for which hospitals may already be reporting.

Comment: Three commenters asked what HHSC's plan is for demonstrating year-over-year progress on quality measures without making quality requirements too difficult to achieve and putting hospital payments at risk.

Response: No changes were made in response to this comment. There is no proposed hospital-specific performance target associated with ACIA or CHIRP reporting at this time. This reporting will be used to evaluate the extent to which hospitals are improving on the defined goals of the Medicaid Managed Care Quality Strategy. CHIRP is a one-year application at this time and will require a new application for future program years.

Comment: One commenter expressed support for the inclusion of quality metric reporting in CHIRP as a condition of receiving payments and strongly recommended that CHIRP build on this to require hospitals to achieve specific outcome goals to earn payments in the ACIA component of the program. The commenter said this requirement will better promote a value-based system that supports financial accountability for the health of patients and maintain the advances of the DSRIP program, which the expansion of UHRIP is partially intended to achieve.

Response: No changes were made in response to this comment. HHSC appreciates the support for quality improvement. CHIRP is a rate enhancement DPP and the program is only designed for one year.

Comment: One commenter said that in order to achieve meaningful quality improvements, provider measures should be in alignment with the same pay for quality measures that MCOs are financially at risk to achieve. The commenter asked if measure calculations will be done for providers based on statewide performance as opposed to MCO or SDA performance. The commenter said that MCOs would prefer HHSC rank providers based on this data and make payment determinations.

Response: No changes were made in response to this comment. The measures and reporting requirements including performance requirements will be addressed annually through the public hearing referenced in §353.1307(e).

Comment: One commenter asked if quality metrics will be adjusted for member risk score, member eligibility class changes, member enrollment duration, and member clinical status.

Response: No changes were made in response to this comment. The measures and reporting requirements including performance requirements will be addressed annually through the public hearing referenced in §353.1307(e).

Comment: Some commenters support HHSC's commitment to evaluating quality achievement on a statewide basis rather than individual hospital basis but requested HHSC provide more clarity on how it will enforce the conditions of participation relating to quality reporting. The commenters also asked for clarification on how HHSC will handle unused or recouped CHIRP funds.

Response: No changes were made in response to this comment. A hospital that fails to submit the required data by deadlines communicated by HHSC will be determined to not be in compliance with program eligibility requirements and will be removed from the program. The provider may also have all funds that they received recouped. There are no redistributions of recouped funds in CHIRP and funds recouped would be retained by the MCO.

Comment: One commenter asked if process and outcomes measures have goals, and if no, whether this is subject to change in the future. The commenter also noted that the rules state that for each program period HHSC will specify the performance requirements and asked if there is a possibility that ACIA measures will become pay for performance measures after baselines are submitted.

Response: No changes were made in response to this comment. There is no proposed hospital-specific performance target associated with ACIA or CHIRP reporting at this time. This reporting will be used to evaluate the extent to which hospitals are improving on the defined goals of the Medicaid Managed Care Quality Strategy. CHIRP is a one-year application at this time and will require a new application for future program years.

Reporting Requirements

Comment: One commenter asked how HHSC will determine if a provider meets the reporting criteria during the first quarter. Will it be determined by an attestation on the application that the provider will provide reporting?

Response: No changes were made in response to this comment. The first quarter of CHIRP FY2022 payments will be based on assumed eligibility and if a hospital does not meet the participation requirements at the first reporting opportunity (currently anticipated in October 2021) the first quarter of payments may be recouped.

Comment: One commenter asked if there is an impact to a hospital's eligibility for rate increase payments if an organization meets the class eligibility requirements for participation in a program component but does not meet minimum volume requirements (MVR) for reporting. The commenter asked whether the organization would still be considered to have met reporting requirements per the rules if MVR excludes them from a program component.

Response: No changes were made in response to this comment. The measures and reporting requirements, including performance requirements, will be addressed annually through the public hearing referenced in §353.1307(e). It is expected that all participating ACIA providers will have the minimum volume to be eligible for reporting measures.

Comment: Two commenters asked if there are carryforward opportunities for reporting in order for an organization to remain eligible for rate increases, if the organization were not able to satisfy reporting requirements for individual or multiple measures in a reporting period but were able to satisfy reporting requirements for other required measures. The commenters asked, "is eligibility 'all or nothing' when it comes to reporting measures?"

Response: No changes were made in response to this comment. CHIRP payment schedules do not allow for carryforward reporting opportunities as were used in DSRIP because program eligibility is tied to a rating period. Participants are required to report all measures for which they are eligible.

Comment: If an organization were able to meet all reporting requirements in a reporting period but in subsequent reporting periods were unable to meet individual or multiple measures in a reporting period, one commenter asked the following.

a. How does this impact previous incentive payments?
b. How does this impact eligibility for future incentive payments?
c. Are there carryforward opportunities for reporting in order for an organization to retain either previous incentive payments and/or eligibility for future rate increases?

Response: No changes were made in response to this comment. Reimbursement through CHIRP is a rate enhancement on paid claims, not an incentive or pay-for-performance payment. A hospital that fails to submit the required data by deadlines communicated by HHSC will be determined to not be in compliance with program

eligibility requirements and will be removed from the program. The provider may also have all funds that it received recouped.

Comment: One commenter said they support the reporting requirements for all measures for which a hospital is eligible as a condition of participation, and agree with the statewide evaluation of progress related to structure measures. However, the commenter is worried that the menu of measures and specs could be overwhelming for small rural hospitals and suggests narrowing the measures within each component.

Response: No changes were made in response to this comment. The measures and reporting requirements including performance requirements will be addressed annually through the public hearing referenced in §353.1307(e).

Comment: In addition to reporting data on Medicaid populations, one commenter recommended HHSC require hospitals to report data on the same metrics for uninsured populations in their care. The commenter noted that statements were made during public information sessions on the 1115 Waiver extension that HHSC has the expectation that hospitals will invest a portion of funds they receive through CHIRP in subsidizing care for the uninsured. The commenter said that requiring hospitals to measure the entire Medicaid and low-income uninsured population as part of CHIRP will ensure health system improvements achieved through DSRIP program are maintained and increased.

Response: No changes were made in response to this comment. The measures and reporting requirements including performance requirements will be addressed annually through the public hearing referenced in §353.1307(e).

MCOs

Comment: Some commenters suggested that if CHIRP is paid on each claim, HHSC require MCOs report to hospitals the contracted base payment portion of each claim and the CHIRP payment on each explanation of payment or explanation of benefit. The commenters said that under the current UHRIP structure, MCOs are not required to inform hospitals what portion of a claims payment is comprised of the directed rate increase and what portion is comprised of the contracted base rate. The commenters said it has been a challenge for hospitals to accurately track and report the current rate increase program payments and work collaboratively with MCOs to address claims adjudication issues.

Response: No changes were made in response to this comment. HHSC encourages MCOs and providers to work together to ensure that information and data are shared between the MCO and provider based upon their mutual agreement and contracts.

Comment: One commenter said they are supportive of HHSC's goals to drive increased quality within the healthcare system and look forward to working in collaboration with HHSC and other stakeholders on the implementation of these

rules and the operationalization of the programs. The commenter requested that managed care implementation meetings begin as soon as possible in order to determine the full operational impacts.

Response: No changes were made in response to this comment. HHSC appreciates the support and will take this comment under advisement.

Comment: One commenter asked how the "classes" of hospitals will be determined, if any change will take place. The commenter also asked how amounts will be calculated and provided to MCOs, given the variation amongst the "classes".

Response: No changes were made in response to this comment. The classes of hospitals are determined based upon the criteria in the definitions section of the rules.

Comment: One commenter requested clarification on the type of data and reporting needed by HHSC and detailed information on how HHSC and the MCOs will exchange data.

Response: No changes were made in response to this comment. The Medicaid managed care contracts between HHSC and the MCOs will describe the parties' responsibilities in implementing CHIRP.

Comment: One commenter asked how HHSC will work with the MCOs, understanding the various claims systems, and the time it may take to make required claims systems modifications.

Response: No changes were made in response to this comment. HHSC will work with MCOs through the spring to answer technical questions through established meeting opportunities.

Comment: One commenter asked for clarification on the expectations related to agreements with providers and how these arrangements will impact existing provider contracts (e.g., will the CHIRP funds, if all metrics are met, be considered the then current Medicaid amount to be paid).

Response: No changes were made in response to this comment. The Medicaid managed care contracts between HHSC and the MCOs will describe the parties' responsibilities in implementing CHIRP.

Comment: One commenter asked how HHSC intends to determine the amount of funding on September 1, 2021, as the payment received will be contingent on specific metrics.

Response: No changes were made in response to this comment. Payments are not contingent upon achievement of specific metrics. HHSC will gather metric data throughout the program year to evaluate success of the program overall. HHSC

may publish hospital-specific data as part of the interim evaluation process and in response to certain federal reporting requirements.

Comment: One commenter asked how HHSC will, and would like MCOs to, deal with those providers eligible to participate if they did not begin tracking the metrics on January 1, 2021, as required, given this change was recently made public.

Response: No changes were made in response to this comment. The Medicaid managed care contracts between HHSC and the MCOs will describe the parties' responsibilities in implementing CHIRP.

Comment: One commenter asked how, or will, HHSC work with the Texas Department of Insurance to waive the risk-based capital requirements (RBC) on these dollars, given the MCOs have no control over the expenditure of same, and will likely be required to be tracked as separate and distinct funds.

Response: No changes were made in response to this comment. This comment is outside the scope of the proposed rules.

Comment: One commenter asked if MCOs will have the ability to review proposed PMPM reimbursement prior to distribution.

Response: No changes were made in response to this comment. MCOs will be able to provide feedback on capitated rates through the normal contracting process.

General

Comment: Three commenters noted that the proposed rules do not mention SDA applications, and instead refer to individual hospital applications and individual governmental entity funding commitments. HHSC's CHIRP quality measures released on January 12, 2021, refer to SDA Learning Collaboratives. The commenters asked what role HHSC envisions for SDAs and the SDA Liaisons under the current Texas managed care hospital rate increase program in the new CHIRP.

Response: No changes were made in response to this comment. Hospitals will individually apply for the program. As part of the DSRIP Transition Plan, HHSC is evaluating the potential for an entity to assist with regional collaboration and/or technical assistance in the proposed DPPs. That role is not within the scope of these rules.

Comment: Commenters are concerned that the increase in CHIRP funding will impact a hospital's entitlement to Medicaid DSH and UC. Several commenters said that HHSC should structure the quality components of CHIRP as a separate quality-based payment program permitted under federal regulations to prevent any impact to DSH and UC funding. Some commenters noted that CMS provides an option for states to provide up to 5 percent of the managed care capitation rate for quality payments under the authority contained in 42 CFR Sec. 438.6(b). Commenters also

asked HHSC to complete modeling to evaluate the impact of the increase in CHIRP funding.

Other commenters said that HHSC should seek to gain approval of a provision in the Section 438.6(c) preprint, and to add language to the proposed rules, that exempts all or a reasonable portion of the ACIA component payments from the Medicaid DSH hospital specific limit calculations in recognition of CHIRP's role in the DSRIP transition and quality reporting requirements. These commenters said that the proposed transformation of UHRIP into CHIRP is largely tied to the ongoing efforts to transition from DSRIP and that DSRIP was feasible largely because DSRIP payments did not offset Medicaid DSH entitlement and did not reduce the payment room under Medicaid managed care actuarial soundness limits.

Response: No changes were made in response to this comment. HHSC considered making a portion of CHIRP a performance-based payment rather than a uniform rate increase but based upon significant stakeholder feedback that was opposed to a pay-for-performance structure, HHSC did not propose one. HHSC will consider this option for future rule amendments. Hospital-specific limits include all payments for inpatient and outpatient services, therefore any uniform rate increased paid for those services will impact the HSL. HHSC will not be restructuring DSH and UC as a result of CHIRP, but may consider which providers are able to receive substantial financial resources through CHIRP and which are not when making future decisions about those programs.

Comment: Two commenters noted that it is unclear whether the state-owned hospitals (a major DSRIP beneficiary) would be eligible to receive any benefit from CHIRP because any CHIRP payments a state hospital receives would result in a dollar-for-dollar reduction to their Medicaid DSH payment caps.

Response: No changes were made in response to this comment. HHSC determines rate increases based upon a number of factors. State-owned hospitals are defined as a potential participating rate class.

Comment: One commenter asked if HHSC has considered adding STAR Kids.

Response: No changes were made in response to this comment. At this time, only STAR and STAR+PLUS encounters are eligible for rate increases in CHIRP. If HHSC decides to include other managed care programs, such as STAR Kids, it will be communicated to MCOs as part of the Medicaid managed care contracts between HHSC and the MCOs.

Comment: One commenter noted that UHRIP eligibility for payment is based on the fact that a hospital provider must have an eligible claim with a contracted MCO of which the hospital resides within the contracted MCO’s SDA. The commenter asked for clarification or additional context on what "contracted with an MCO" means or how it is accomplished. The commenter also asked HHSC to define “in-network” and what it means in this context. Is it that the hospital has to reside in the SDA with the applicable MCO?

Response: No changes were made in response to this comment. UHRIP eligibility is now the same as CHIRP eligibility. For CHIRP, a hospital must have at least one claim with an MCO in order to receive a rate increase paid by the MCO. To be considered in-network, the provider has to have a contract with the MCO for the delivery of covered services to the MCO's members.

Comment: One commenter asked what MCO programs will be eligible for the CHIRP program. The commenter also asked HHSC to provide an SDA map of the MCOs that have these programs by SDA.

Response: No changes were made in response to this comment. STAR and STAR+PLUS encounters are eligible for rate increases in CHIRP. The second comment is outside the scope of the rule.

Comment: One commenter recommended HHSC consider reducing the amount of money available in the CHIRP program and use the available budget neutrality room to develop a separate program to ensure uninsured populations receive quality care. The commenter said that the shift to primarily Medicaid payment support after nine years of support for both Medicaid and the uninsured in DSRIP is too abrupt to insure seamless transition of care for the uninsured population and that HHSC must offer additional funding support for uninsured populations.

Response: No changes were made in response to this comment. HHSC is unable to direct payments through managed care for services provided to persons who are not enrolled in Medicaid managed care. HHSC believes that the existing DSH and UC programs will continue to provide financial support for non-Medicaid populations.

Comment: The CHIRP dollars and other programs under the waiver will be limited by the 1115 waiver budget-neutrality capacity and the amount of IGT funds available for the program. One commenter strongly supports carrying forward the maximum amount of budget neutrality dollars in the waiver. The commenter said this will allow Texas to move toward a system that reflects the actual cost of care and continues funding uncompensated care costs.

Response: No changes were made in response to this comment. This comment is outside the scope of the proposed rules.

Comment: One commenter asked if there will be any accommodations due to the impact of COVID.

Response: No changes were made in response to this comment. This comment is outside the scope of the proposed rules.

STATUTORY AUTHORITY

The amendment and new sections are authorized by Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; 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-1), 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 Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

This agency hereby certifies that this adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 424-6637 or (512) 462-6223.