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 §353.1306, concerning the Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021, and to §353.1307 concerning Quality Metrics for the Comprehensive Hospital Increase Reimbursement Program.

Section 353.1306 is adopted with changes to the proposed text as published in the November 17, 2023, issue of the *Texas Register* (48 TexReg 6676). This rule will be republished.

Section 353.1307 is adopted with changes to the proposed text as published in the November 17, 2023, issue of the *Texas Register* (48 TexReg 6676). This rule will be republished.

BACKGROUND AND JUSTIFICATION

HHSC adopts modifications to the Comprehensive Hospital Increase Reimbursement Program (CHIRP), beginning with the State Fiscal Year (SFY) 2025 rating period to promote the advancement of the quality goals and strategies the program is designed to advance.

HHSC sought and received authorization from the Centers for Medicare & Medicaid Services (CMS) to create CHIRP for SFY 2022 as part of the financial and quality transition from the Delivery System Reform Incentive Payment Program (DSRIP). One component of CHIRP existed as a stand-alone directed payment program for SFY 2018–SFY 2021, but that component was fully folded into CHIRP beginning in SFY 2022. HHSC has not made significant modifications to CHIRP since its inception in SFY 2022. Directed payment programs authorized under 42 C.F.R. §438.6(c), including CHIRP, are expected to continue to evolve over time so the program can continue to advance the quality goal or objective the program is intended to impact.

The adopted amendments create a new pay-for-performance incentive payment through a third component in CHIRP, the Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA). The classes of hospitals that may participate in APHRIQA will be determined by HHSC on an annual basis, and the decision will be made by HHSC to identify the classes of hospitals and the amount of funding based on the factors detailed in the rule, including the extent to which a hospital class contributes toward advancing the goals and objectives identified in the state's managed care quality strategy. HHSC will prioritize transitioning payments to pay-for-performance for classes or providers that, based

on HHSC's financial models, receive payments that are projected to potentially exceed the cost of care provided and with reference to which HHSC's modeling indicates that the transition will stabilize overall funding for the Medicaid program and Medicaid providers. For state fiscal years beginning with SFY 2025, HHSC does not anticipate that behavioral health hospitals or rural hospitals will be included in a pay-for-performance program.

The funds for payment of the APHRIQA component will be transitioned from the existing uniform rate increase components of the Uniform Hospital Rate Increase Payment (UHRIP). The Average Commercial Incentive Award (ACIA) will be paid using a scorecard that directs managed care organizations (MCOs) to pay providers for performance achievements on quality outcome measures. Payments will be distributed under APHRIQA on a monthly, quarterly, semi-annual, or annual basis that aligns with the measurement period determined for quality metrics reporting. The adopted amendments will meet the need for continued program evolution and development for year 4 (Fiscal Year 2025) of CHIRP to further the goals of the Texas Healthcare Transformation and Quality Improvement Program 1115 demonstration waiver (Texas 1115 Waiver) and will lead to continued quality improvements in the healthcare delivery system in Texas.

COMMENTS

The 31-day comment period ended December 18, 2023.

During this period, HHSC received comments regarding the proposed rules from 18 organizations, including Medical Center Health System; Midland Memorial Hospital; Teaching Hospitals of Texas; Children's Hospital Association of Texas; Texas Organization of Rural and Community Hospitals; Baylor Scott & White; HCA Healthcare; Memorial Hermann; Tenet Health; Texas Health Resources; Christus Health; Texas Association of Behavioral Health Systems; Oceans Healthcare; Universal Health Services; Texas Essential Healthcare Partnerships; Texas Hospital Association; Steward Health Care System; and Texas Association of Voluntary Hospitals. A summary of comments relating to §353.1306, concerning the Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021, and to §353.1307 concerning Quality Metrics for the Comprehensive Hospital Increase Reimbursement Program and HHSC's responses follows.

Regarding §353.1306, concerning the Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021:

<u>Allocation Methodology</u>

Comment: A commenter provided a suggestion to allocate funds for the APHRIQA component by accounting for, by hospital class, uninsured costs in addition to any Medicaid long fall. The commenter also provided a suggested methodology for this funding allocation.

Response: HHSC acknowledges the comment. The comment is not relevant to the rule because the comment describes a preference for how HHSC will determine the allocation of funding available to providers across CHIRP components and is, therefore, outside the scope of the rule amendment. No revision to the rule text was made in response to this comment.

Comment: Several commenters provided suggestions to allocate the minimum amount necessary for the APHRIQA component to achieve HHSC's policy goals.

Response: HHSC acknowledges the comment. The comment is not relevant to the rule because the comment relates to the allocation methodology of fund allocations to be used for the APHRIQA component and is, therefore, outside the scope of the rule amendment. No revision to the rule text was made in response to this comment.

Comment: A comment was received in support of the Proposed Rule text that allows HHSC discretion to set percentage reductions to the ACIA and UHRIP components (that form the basis of the APHRIQA allocation) on a Service Delivery Area (SDA)-class basis to the extent that HHSC agrees to implement a model that sets percentage reductions in line with holistic considerations of hospital contributions to the Medicaid program. Based on this model, reductions are made by applying a mandatory reduction to a class's CHIRP allocation when its Medicaid payments exceed its Medicaid and uninsured charity care costs; and imposing a payment floor equal to a percent of the uninsured charity care costs incurred by a class to incentivize hospitals to continue providing care.

Response: HHSC acknowledges the comment. The portion of the comment detailing specific allocation methodology for fund allocations is not relevant because it is outside of the scope of this rule amendment. No revision to the rule text was made in response to this comment.

Comment: Several commenters provided comments requesting the removal of the 90 percent of the Average Commercial Reimbursement (ACR) limit and for HHSC to seek approval for CHIRP payments to be no less than 90 percent of the ACR.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. HHSC must consider the available budget neutrality room available under the Texas 1115 Waiver, the reasonableness of payments available to providers under CHIRP, and other factors when determining what percentage of ACR will be available under the program. Additionally, the 90 percent of the ACR limitation is the result of extensive negotiations with CMS. No revision to the rule text was made in response to this comment.

Unearned APHRIQA payments redistributions

Comment: A commenter requested that HHSC revise the wording in §353.1306 (h)(2)(C) to always calculate any unearned APHRIQA redistribution at the SDA

level, as opposed to calculating any unearned APHRIQA redistribution at the class level within the SDA and the SDA level if applicable under the rule.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. Because the funds for the APHRIQA component are allocated on a class and SDA basis, it is by design that §353.1306 (h)(2)(C) allows hospitals in the same class in the same SDA the first opportunity receive any available unearned APHRIQA redistribution payments based upon their ability to successfully achieve their measures.

Timing

Comment: A comment was received in support of the timing of the rule change and stated that the change is both necessary and important to protect Texas' rural healthcare safety net.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: Several commenters urged postponement of any alterations to the CHIRP program until the impact of changes is fully understood due to uncertainties in broader Federal and state Medicaid supplemental payment landscapes.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. The proposed amendment and the creation of the APHRIQA component is a proactive mechanism to further the goals of the Texas 1115 Waiver as the CHIRP program matures. In addition, the creation of the APHRIQA component is a mechanism for the state to effectively respond to changes in the larger Medicaid supplemental payment landscapes as pay-for-performance and quality initiatives become increasingly important strategies to drive healthcare improvement and innovation on both the Federal and state levels. No revision to the rule text was made in response to this comment.

Comment: A commenter stated that reallocating funds to the APHRIQA component would lead to a reduction in payments that will begin immediately on September 1, 2024, while payments earned for achieving quality will be delayed until after the program year concludes in September 2025, creating significant cash flow challenges for hospitals.

Response: HHSC disagrees with the commenter that the creation of the APHRIQA component is a reduction in payments because the total payments potentially available to providers will not necessarily be changed by the creation of the third component. However, HHSC understands the commenter's concern that, if measure achievement is calculated only once per year, waiting for full payment could create cash flow concerns for certain providers. Therefore, in response to the commenter, HHSC will modify the rule text upon adoption to create an option for a provider to elect, on its enrollment application, to receive two interim payments per program period if measure achievement is calculated only once per year. Each interim

payment will be equal in amount to an estimated 20 percent of the provider's potential total APHRIQA payment if the provider were to earn 100 percent of available payments under the APHRIQA component. The interim payments will be reconciled with final payments after measure achievement has been determined. Interim payments are subject to being recouped and are not an indication of presumptive measure achievement.

Funding Risk and Instability

Comment: Several comments were received against the proposed rule changes, stating that the rule changes will lead to unpredictability and instability in the Medicaid program because the proposed rule allows HHSC to make decisions on the percentage for allocation to the program components each year. The commenters also stated that the proposed rule could lower the funds available to providers and lead to program funds being put at risk for children's hospitals that are heavily dependent on Medicaid.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. The proposed rule allows HHSC to make decisions on the percentage for allocation to the program components each year so HHSC can ensure that funding allocation advances the goals of the Texas 1115 Waiver and protects the overall stability of the healthcare system of Texas. The proposed rule does not inherently lower the amount of funds available to providers but rather creates a new pay-for-performance component to incentivize quality improvement and improved health outcomes for Medicaid recipients in Texas. Additionally, HHSC must consider the available budget neutrality room available under the Texas 1115 Waiver, the reasonableness of payments available to providers under CHIRP, and other factors when determining what percentage of ACR will be available under the program. No changes to the rule text were made in response to this comment.

IMD Exclusion

Comment: Several commenters requested that institutions for mental diseases (IMDs) be officially excluded from the APHRIQA component for future years. Commenters noted that, consistent with federal law, IMDs do not receive CHIRP payments on their entire population of managed Medicaid inpatient claims; and, therefore, commenters state that moving IMDs to the APHRIQA component would further inequities for IMDs.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. As the CHIRP program continues to mature and to ensure that the program continues to advance the quality goals and strategies of Texas Medicaid managed care as required by 42 C.F.R. §438.6(c), HHSC may need to incentivize different classes to achieve programmatic and quality goals by aligning payments in different program components.

CHIRP Hospital Class Definition

Comment: A commenter requested that HHSC update the CHIRP class definition to create a separate Children's free-standing psychiatric facilities class or to update the Children's class definition to include children's free-standing psychiatric facilities.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. HHSC did not propose modifications of class definitions in the rule proposal; and, consequently, other program participants and the public did not have an opportunity to comment on such a change. Therefore, HHSC is unable to consider all potential perspectives on this matter. No revision to the rule text was made in response to this comment.

Disproportionate Share Hospital (DSH) and Uncompensated Care (UC) Condition of Participation

Comment: Several commenters requested clarification for DSH and UC conditions of participation associated with APHRIQA.

Response: HHSC acknowledges the comment. No revision to the rule text was made in response to this comment. The current proposed rule text describes the APHRIQA component as a voluntary component, which is true when considering only CHIRP participation. The specifications for participation in the APHRIQA component to meet the DSH and UC programs' conditions of participation are described in Title 1 Texas Administrative Code (1 TAC) §355.8065(e)(9) and §355.8212(c)(1)(F). These references state that it will be required for all non-rural hospitals, except for state-owned hospitals, to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs.

Lump sum payments

Comment: Several commenters requested for all CHIRP components to be paid in lump sums, not just the APHRIQA component, citing ease of tracking and the advantage of easing cash flow burdens for hospitals.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. It is more appropriate for a uniform rate increase to be paid on claims at the time of adjudication.

MCO payment reporting requirements

Comment: Several commenters requested that HHSC require MCOs to report to hospitals the contracted base payment portion of each claim and the UHRIP and ACIA payment on each claim.

Response: HHSC acknowledges the comment. While HHSC supports payment transparency between MCOs and hospitals, the content of reporting between MCOs and hospitals is outside the scope of the rule being amended. No revision to the rule text was made in response to this comment because the comment is outside of the scope of the rule being amended.

Data corrections

Comment: Several commenters requested additional specificity regarding the timelines for data corrections. The commenters state that the rule as amended imposes a deadline for hospitals to request corrections to identified data errors but does not impose a deadline for HHSC to provide calculation files to the providers for verification.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. The proposed rule amendment provides a formal cut-off by which corrections should be submitted. Providers, however, are encouraged to submit corrections as soon as the need for corrections is discovered. The CHIRP calculations, including supporting worksheets, will continue to be made available through the public web postings of CHIRP preprint submissions. Postings include both draft and official CHIRP calculations, as well as Intergovernmental Transfer (IGT) commitment and notification files that will contain information for providers' verifications. The timing of these notifications is described in §353.1306(i).

General Comments

Comment: A commenter addressed a potential incentive program under the authorization of 42 C.F.R. §438.6(b) and made several requests related to a potential program developed under that authority.

Response: HHSC acknowledges the comment. No revision to the rule text was made in response to this comment because CHIRP is authorized under 42 C.F.R. §438.6(c). The comment discusses an incentive program authorized by 42 C.F.R. §438.6(b), which is outside of the scope of the proposed rules.

Comment: A comment was received against the proposed rule, stating that the rule change would conflict with the intention of the CHIRP program to benchmark Medicaid payments to external sources such as Medicare payments and average commercial rates and to pay providers closer to fair market value of the Medicaid services that hospitals provide.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. CHIRP was designed to incentivize hospitals to improve access, quality, and innovation in the provision of hospital services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy. The rule as amended furthers the goals and objectives of the state's managed care quality

strategy and will lead to continued quality improvements in the healthcare delivery system in Texas.

Comment: A commenter requested that §353.1306(e)(2)(E) be removed as it is no longer applicable in the CHIRP program.

Response: HHSC acknowledges the comment. No revision to the rule text was made in response to this comment because, while this factor is not currently considered when determining a class's eligibility for rate increases in the program, this historical factor of consideration may be used in the future administration of the program.

Comment: A comment was received in support of the rule text language for §353.1306(g)(3); §353.1306(g)(4); and §353.1306(h), including §353.1306(h)(2)(C).

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Regarding §353.1307, concerning Quality Metrics for the Comprehensive Hospital Increase Reimbursement Program:

Comment: One commenter recommended that HHSC solicit industry feedback on APHRIQA metrics sooner through a mechanism HHSC used for DSRIP under the Texas 1115 Waiver – Bundle Advisory Teams. The Bundle Advisory Teams consisted of clinicians from participating hospitals with operational expertise, which provided feedback on the quality measures to include in the program.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. HHSC convened a stakeholder workgroup of representatives from hospitals and hospital associations to assist in selecting quality metrics for CHIRP (specifically APHRIQA), including encouraging participation from clinicians. This workgroup met six times over several months.

Comment: One commenter indicated that HHSC should amend the rules to put specified guardrails or guiding principles in the rules to give hospitals the notice they need to implement programs, policies, and additional steps to meet new or altered quality metrics. They also requested that achievement goals be established in advance to cover a several-year period, providing participating providers with adequate notice of the goal and the ability to put processes in place to achieve the desired outcomes over time.

Response: HHSC acknowledges the comment. Although HHSC does not agree with the comment in the comment in its entirety, HHSC has updated the rules to allow 30 calendar days for public comment. In the future, HHSC will post proposed quality metrics and requirements by August 10 and final quality metrics and requirements by October 1. HHSC has historically engaged stakeholders prior to posting the proposed metrics and quality requirements for public comment and has

reviewed historic performance when considering changes to the quality requirements. HHSC intends to continue to engage stakeholders and to review historic performance when selecting metrics and quality requirements.

HHSC declines to make the additional changes to the rules suggested by this commenter. HHSC engaged stakeholders in extensive conversations regarding program design and quality metrics before proposing the rule amendment. The program must be approved on an annual basis under 42 C.F.R. § 438.6(c).

Comment: One commenter opposed HHSC's proposal to shorten the timeframe for hospitals to furnish information to HHSC related to quality metrics and performance requirements from thirty (30) days to twenty (20) days. They stated the shorter timeframe will increase the administrative burden on participating providers.

Response: HHSC acknowledges the comment and maintained the 30 days for requests for additional information or corrections. Hospitals will continue to have 30 days to submit reporting.

Comment: Several commenters expressed concern with the length and timing of the public comment period for CHIRP quality metrics and requirements. The commenters state it is possible that a significant portion of each hospital class's CHIRP payments could be in the APHRIQA component in any future program year. As such, the process used to choose performance metrics is important for all providers. They state that allowing only fifteen (15) business days to assess and comment on the proposed metrics and performance requirements is insufficient. CHIRP hospitals need at least thirty (30) calendar days to meaningfully review HHSC's proposals and provide substantive feedback, especially in light of HHSC's ability to pick new metrics from year to year. Providing a longer process to review and submit feedback is also important, considering the general timing of this process and how it lines up with other Texas programs. The fifteen-day period will presumably overlap with the Thanksgiving holiday when many people are traveling, and it also overlaps with the annual due date for hospitals' DSH/UC Applications. Regardless of when HHSC publishes the annual list of pay-for-performance metrics and performance requirements, hospitals should be afforded at least thirty (30) calendar days to submit comments and participate in a public hearing.

Response: HHSC acknowledges these comments and has updated the rule to allow 30 calendar days for public comment. HHSC will post proposed quality metrics and requirements by August 10 and final quality metrics and requirements by October 1. HHSC has previously been able to engage stakeholders prior to posting the proposed metrics and quality requirements for public comment and HHSC plans to continue this practice when necessary and appropriate.

Comment: A commenter recommended that HHSC work with CMS to allow for meeting benchmark performance levels without requiring improvement over self when high levels of benchmark performance have been met.

Response: HHSC acknowledges the comment. No revision to the rule text was made in response to this comment because the comment on specific program quality metric achievement targets is not directly relevant to the content of the proposed rule amendment.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-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.

The amendment affects Texas Government Code, Chapters 531 and 533, and Texas Human Resources Code, Chapter 32.

This agency hereby certifies that the 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) 487-3480.

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
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SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

§353.1306. Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021.

(a) Introduction. This section establishes the Comprehensive Hospital Increase Reimbursement Program (CHIRP) for program periods on or after September 1, 2021, wherein the Health and Human Services Commission (HHSC) directs a managed care organization (MCO) to provide a uniform reimbursement increase to hospitals in the MCO's network in a designated service delivery area (SDA) for the provision of inpatient services, outpatient services, or both. This section also describes the methodology used by HHSC to calculate and administer such reimbursement increases. CHIRP is designed to incentivize hospitals to improve access, quality, and innovation in the provision of hospital services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions).

(1) Average Commercial Reimbursement (ACR) gap--The difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid for the same services.

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

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

(4) Inpatient hospital services--Services ordinarily furnished in a hospital for the care and treatment of inpatients under the direction of a physician or dentist, or a subset of these services identified by HHSC. Inpatient hospital services do not include skilled nursing facility or intermediate care facility services furnished by a hospital with swing-bed approval, or any other services that HHSC determines should not be subject to the rate increase.

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

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

(7) Outpatient hospital services--Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients of a hospital under the direction of a physician or dentist, or a subset of these services identified by HHSC. HHSC may, in its contracts with MCOs governing rate increases under this section, exclude from the definition of outpatient hospital services such services as are not generally furnished by most hospitals in the state, or such services that HHSC determines should not be subject to the rate increase.

(8) Program period--A period of time for which HHSC will contract with participating MCOs to pay increased capitation rates for the purpose of provider payments under this section. Each program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year.

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

(10) State-owned non-IMD hospital--A hospital that is owned and operated by a state university or other state agency that is not primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental disease.

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

(c) Conditions of Participation. As a condition of participation, all hospitals participating in CHIRP must allow for the following.

(1) The hospital must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 21 calendar days and the final date of the enrollment period will be at least nine days prior to the IGT notification.

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

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

(C) A hospital is required to maintain all supporting documentation at the hospital for any information provided under subparagraph (B) of this paragraph for a period of no less than 5 years.

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

program.

(2) The entity that owns the hospital must certify, on a form prescribed by HHSC, that no part of any payment made under the CHIRP will be used to pay a contingent fee and that the entity's agreement with the hospital does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the hospitals' receipt of CHIRP funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) If a provider has changed ownership in the past five years in a way that impacts eligibility for this program, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, this program.

(4) All quality metrics for which a hospital is eligible based on class, as described in subsection (d) of this section, must be reported by the participating hospital.

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

(d) Classes of participating hospitals.

(1) HHSC may direct the MCOs in an SDA that is participating in the program described in this section to provide a uniform percentage rate increase or another type of payment to all hospitals within one or more of the following classes of hospital with which the MCO contracts for inpatient or outpatient services:

(A) children's hospitals;

(B) rural hospitals;

(C) state-owned non-IMD hospitals;

(D) urban hospitals;

(E) non-state-owned IMDs; and

(F) state-owned IMDs.

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

(e) Eligibility. HHSC determines eligibility for rate increases and other payments by SDA and class of hospital.

(1) Service delivery area. Only hospitals in an SDA that includes at least one sponsoring governmental entity are eligible for a rate increase.

(2) Class of hospital. HHSC will identify the class or classes of hospital within each SDA described in paragraph (1) of this subsection to be eligible for a rate increase or other payment. HHSC will consider the following factors when identifying the class or classes of hospital eligible for a rate increase or other payment and the percent increase applicable to each class:

(A) whether a class of hospital contributes more or less significantly to the goals and objectives in HHSC's managed care quality strategy, as required in 42 C.F.R. §438.340, relative to other classes;

(B) which class or classes of hospital the sponsoring governmental entity wishes to support through IGTs of public funds, as indicated on the application described in subsection (c) of this section;

(C) the estimated Medicare gap for the class of hospitals, based upon the upper payment limit demonstration most recently submitted by HHSC to CMS;

(D) the estimated ACR gap for the class or individual hospitals, as indicated on the application described in subsection (c) of this section; and

(E) the percentage of Medicaid costs incurred by the class of hospital in providing care to Medicaid managed care clients that are reimbursed by Medicaid MCOs prior to any rate increase administered under this section.

(f) Services subject to rate increase and other payment.

(1) HHSC may direct the MCOs in an SDA to increase rates for all or a subset of inpatient services, all or a subset of outpatient services, or all or a subset of both, based on the service or services that will best advance the goals and objectives of HHSC's managed care quality strategy.

(2) In addition to the limitations described in paragraph (1) of this subsection, rate increases for a state-owned IMD or non-state-owned IMD are limited to inpatient psychiatric hospital services provided to individuals under the age of 21 and to inpatient hospital services provided to individuals 65 years or older.

(3) CHIRP rate increases will apply only to the in-network managed care claims billed under a hospital's primary National Provider Identifier (NPI) and will not be applicable to NPIs associated with non-hospital sub-providers owned or operated by a hospital.

(g) CHIRP capitation rate components. For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, CHIRP funds will be paid to MCOs through two components of the managed care per member per month (PMPM) capitation rates. For program periods beginning on or after September 1, 2024, CHIRP funds will be paid to MCOs through three components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of CHIRP funds to the enrolled hospitals may be based on each hospital's performance related to the quality metrics as described in §353.1307 of this subchapter (relating to Quality Metrics for the Comprehensive Hospital Increase Reimbursement

Program). The hospital must have provided at least one Medicaid service to a Medicaid client for each reporting period to be eligible for payments.

(1) In determining the percentage increases described under subsection (h)(1) of this section, HHSC will consider:

(A) information from the participants in the SDA (including hospitals, managed-care organizations, and sponsoring governmental entities) on the amount of IGT the sponsoring governmental entities propose to transfer to HHSC to support the non-federal share of the increased rates for the first six months of a program period, as indicated on the applications described in subsection (c) of this section;

(B) the class or classes of hospital determined in subsection (e)(2) of this section;

(C) the type of service or services determined in subsection (f) of this section;

(D) actuarial soundness of the capitation payment needed to support the rate increase;

(E) available budget neutrality room under any applicable federal waiver programs;

(F) hospital market dynamics within the SDA; and

(G) other HHSC goals and priorities.

(2) The Uniform Hospital Rate Increase Payment (UHRIP) is the first component.

(A) The total value of UHRIP will be equal to a percentage of the estimated Medicare gap on a per class basis.

(B) Allocation of funds across hospital classes will be proportional to the combined Medicare gap of each hospital class within an SDA to the total Medicare gap of all hospital classes within the SDA.

(3) The Average Commercial Incentive Award (ACIA) is the second component.

(A) The total value of ACIA will be equal to a percentage of the ACR gap less payments received under UHRIP, subject to the limitations described by subparagraph (B) of this paragraph.

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

(C) The ACIA payment for the class will be equal to the minimum of the sum

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

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

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

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

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

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

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

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

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

(h) Distribution of CHIRP payments.

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

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

(B) UHRIP rate increases will be determined by HHSC to be the percentage that is estimated to result in payments for the class that are equivalent to the amount described under subsection (g)(2)(A) of this section.

(C) ACIA will be determined by HHSC to be a percentage that is estimated to result in payments for the hospital that are equivalent to the amount described under subsection (g)(3)(D) of this section.

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

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

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

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

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

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

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

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

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

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

(3) HHSC will limit the amounts paid to providers determined pursuant to this subsection to no more than the levels that are supported by the amount described in subsection (i)(3) of this section. Nothing in this section may be construed to limit the authority of the state to require the sponsoring governmental entities to transfer additional funds to HHSC following the reconciliation process described in §353.1301(g) of this subchapter, if the amount previously transferred is less than the non-federal share of the amount expended by HHSC in the SDA for this program.

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

(i) Non-federal share of CHIRP payments. The non-federal share of all CHIRP payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support CHIRP.

(1) HHSC will communicate suggested IGT responsibilities for the program

period with all CHIRP hospitals at least 10 calendar days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars to be available under the CHIRP program for the program period as determined by HHSC, plus eight percent; and forecast member months for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under CHIRP for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled hospitals will meet 100 percent of their quality metrics and maintain consistent utilization with the prior year.

(2) Sponsoring governmental entities will determine the amount of IGT they intend to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC no later than 21 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity intends to transfer to HHSC.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred no fewer than 14 business days before IGT transfers are due. Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. Sponsoring governmental entities will transfer the second half of the IGT amount by a date determined by HHSC, but no later than December 1. HHSC will publish the IGT deadlines and all associated dates on its Internet website no later than March 15 of each year.

(j) Effective date of rate increases. HHSC will direct MCOs to increase rates under this section beginning the first day of the program period that includes the increased capitation rates paid by HHSC to each MCO pursuant to the contract between them.

(k) Changes in operation. If an enrolled hospital closes voluntarily or ceases to provide hospital services in its facility, the hospital must notify the HHSC Provider Finance Department by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide hospital services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

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

(m) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during the program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period

using the methodology described in §353.1301(g) of this subchapter.

(n) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) and §353.1301(k) of this subchapter.

§353.1307. Quality Metrics for the Comprehensive Hospital Increase Reimbursement Program.

(a) Introduction. This section establishes the quality metrics for the Comprehensive Hospital Increase Reimbursement Program (CHIRP).

(b) Definitions. Terms that are used in this and other sections of this subchapter may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1306 of this subchapter (relating to the Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021).

(c) Quality metrics. For each program period, HHSC will designate one or more quality metrics for each CHIRP capitation rate component as described in §353.1306(g) of this subchapter. Any quality metric included in CHIRP will be evidence-based and will be identified as a structure, process, or outcome measure. HHSC may modify quality metrics from one program period to the next. The proposed quality metrics for a program period will be presented to the public for comment in accordance with subsection (g) of this section.

(d) Performance requirements. For each program period, HHSC will specify the performance requirements associated with designated quality metrics. The proposed performance requirements for a program period will be presented to the public for comment in accordance with subsection (g) of this section. Achievement of performance requirements will trigger payments as described in §353.1306 of this subchapter.

(e) Quality metrics and program evaluation. HHSC will use reported performance of 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) of this subchapter.

(1) All quality metrics for which a hospital is eligible based on class must be reported by the participating hospital as a condition of participation.

(2) Participating hospitals must stratify any reported data by payor type and must report data according to requirements published under subsection (h) of this section.

(f) Participating Hospital Reporting Frequency.

(1) Participating hospitals will be required to report on quality metrics semiannually unless otherwise specified by the metric.

(2) Participating hospitals will also be required to furnish information and data related to quality metrics and performance requirements established in accordance with subsection (g) of this section within ~~20~~ 30 calendar days after a request from

HHSC for more information.

(g) Notice and hearing.

(1) HHSC will publish notice of the proposed metrics and their associated performance requirements no later than ~~November 15~~August 10 of the calendar year that precedes the first month of the program period. The notice must be published either by publication on HHSC's website or in the *Texas Register.* The notice required under this section will include the following:

(A) instructions for interested parties to submit written comments to HHSC regarding the proposed metrics and performance requirements; and

(B) the date, time, and location of a public hearing.

(2) Written comments will be accepted within ~~15~~ 30 ~~business~~ calendar days of publication. There will also be a public hearing within that ~~15~~30-day period to allow interested persons to present comments on the proposed metrics and performance requirements.

(h) Quality metric publication. Final quality metrics and performance requirements will be provided through the CHIRP quality webpage on HHSC's website on or before ~~December 31~~October 1 of the calendar year that precedes the first month of the program period.

(i) Alternate measures may be substituted for measures proposed under subsection (g) of this section or published under subsection (h) of this section if required by the Centers for Medicare and Medicaid Services for federal approval of the program. If Centers for Medicare and Medicaid Services requires changes to quality metrics or performance requirements after ~~December 31~~October 1, HHSC will provide notice of the changes through HHSC's website.

(j) Evaluation Reports.

(1) HHSC will evaluate the success of the program based on a statewide review of reported metrics. HHSC may publish more detailed information about specific performance of various participating hospitals, classes of hospitals, or service delivery areas.

(2) HHSC will publish interim evaluation findings regarding the degree to which the arrangement advanced the established goal and objectives of each capitation rate component.

(3) HHSC will publish a final evaluation report within 270 days of the conclusion of the program period.