ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 2. TEXAS ETHICS COMMISSION

CHAPTER 18. GENERAL RULES CONCERNING REPORTS

1 TAC §18.15

The Texas Ethics Commission (the Commission) adopts amendments to Texas Ethics Commission rules in Chapter 18. Specifically, the Commission adopts amendments to §18.15, regarding Additional Fine. The amendments are adopted without changes to the proposed text as published in the February 5, 2021, issue of the *Texas Register* (46 TexReg 897). This rule will not be republished.

For a filer to be subject to the additional penalty, *two* conditions must be met: (1) the filer must fail to file a required report within 30 days of the deadline, and (2) the filer must fail to pay the statutory penalty within 10 days of receiving a warning letter from the Commission. See Texas Election Code §254.042(b) (campaign finance); Tex. Gov't Code §305.033(b) (lobby); Tex. Gov't Code §572.033(b) (personal financial statement). If both of those conditions are met, then the filer is liable for an additional civil penalty "in an amount determined by commission rule...."

No public comments were received on these amended rules.

The amendments are adopted under Texas Government Code §571.062, which authorizes the Commission to adopt rules to administer Title 15 of the Election Code.

The amended rules affect Title 15 of the Election Code.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on March 31, 2021.

TRD-202101402
J.R. Johnson
General Counsel
Texas Ethics Commission
Effective date: April 20, 2021
Proposal publication date: February 5, 2021
For further information, please call: (512) 463-5800

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CHAPTER 20. REPORTING POLITICAL CONTRIBUTIONS AND EXPENDITURES

SUBCHAPTER F. REPORTING REQUIREMENT FOR A GENERAL PURPOSE COMMITTEE

1 TAC §20.434

The Texas Ethics Commission (the Commission) adopts amendments to Texas Ethics Commission rules in Subchapter F of Chapter 20. Specifically, the Commission adopts amendments to §20.434, regarding Alternate Reporting Requirements for General-Purpose Committees. The amendments are adopted without changes to the proposed text as published in the February 5, 2021, issue of the *Texas Register* (46 TexReg 898) and will not be republished.

The Commission needs to correct some outdated cross-references in §20.434. Specifically, §20.434 references §20.433(a)(11) and §20.433(a)(20)(B), but those references have been out of date since 2012, when §20.433 was amended. To reflect those 2012 changes, the cross-references in §20.434 have been amended to §20.433(11) and §20.433(25)(B).

No public comments were received on this amended rule.

The amendments are adopted under Texas Government Code §571.062, which authorizes the Commission to adopt rules to administer Title 15 of the Election Code.

The amended rule affects Title 15 of the Election Code.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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J.R. Johnson
General Counsel
Texas Ethics Commission
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For further information, please call: (512) 463-5800

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PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353. MEDICAID MANAGED CARE

SUBCHAPTER O. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

1 TAC §353.1320, §353.1322

The Texas Health and Human Services Commission (HHSC) adopts new §353.1320, concerning Directed Payment Program for Behavioral Health Services; and new §353.1322, concerning Quality Metrics for the Directed Payment Program for Behavioral Health Services.

New §353.1320 and §353.1322 are adopted with changes to the proposed text as published in the January 29, 2021, issue of the *Texas Register* (46 TexReg 684). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the new rules is to describe the circumstances under which HHSC will direct a Medicaid managed care organization (MCO) to provide a uniform percentage rate increase and a uniform dollar increase in the form of prospective monthly payments to community mental health centers (CMHCs) in the MCO's network in a participating service delivery area (SDA) for the provision of services by CMHCs. The new rules also describe the methodology used by HHSC to determine the amounts of the rate and dollar increases.

HHSC is encouraging CMHCs to earn certification as Certified Community Behavioral Health Clinics (CCBHC) to implement processes and delivery of care that are consistent with the CCBHC model. Currently, Medicaid payments to CMHCs that are either CCBHC entities or in the process of getting certified, made through either the fee-for-service (FFS) or managed care models, may not cover all costs of Medicaid allowable services provided by CMHCs. HHSC is adopting these rules to establish a new program developed under the Delivery System Reform Incentive Payment program (DSRIP) Transition Plan.

HHSC anticipates that the increased payments to participating CMHCs will sustain access to services, promote better health outcomes, and increase focus on improving quality goals that are established as part of the Texas Medicaid program.

In May 2016, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that allows a state to direct expenditures under its contract with MCOs under certain limited circumstances. Under the federal rule, a state may direct an MCO to raise rates for a class of providers of a particular service by a uniform dollar amount or percentage, or as a performance incentive, subject to approval of the contract arrangements by CMS. To obtain approval, the arrangements must be based on the utilization and delivery of services; direct expenditures equally, and using the same terms of performance, for a class of providers of a particular service; advance at least one of the goals and objectives of the state's Medicaid quality strategy and have an evaluation plan to measure the effectiveness of the arrangements at doing so; not condition provider participation on an intergovernmental transfer (IGT); and not be automatically renewed.

These rules authorize HHSC to use IGTs from sponsoring governmental entities to support MCO capitation payment increases in one or more SDAs. Each MCO within the SDA will be contractually required by the state to increase payments by a uniform percentage and dollar amount for the applicable component, respectively, for one or more classes of CMHCs that provide services within the SDA.

Conceptual Framework

Eligibility:

HHSC determines eligibility for payments by CMHC class. The SDA must have at least one sponsoring governmental entity willing to provide IGT to support increased payments. Also, to be eligible for the reimbursement increase, a CMHC must be within a class designated by HHSC to receive the increase.

There will be two classes of CMHCs: CMHCs that have attained certification as a CCBHC and those that have not. The classifications allow HHSC to direct reimbursement increases where they align with the quality goals of the program. The reimbursement increase will be uniform for all CMHCs within each class.

Services subject to rate or dollar increase:

HHSC may direct rate increases for all or a subset of services provided by CMHCs. The services subject to the rate increase will focus on CCBHC procedure codes in an effort to advance the goals and objectives of HHSC's managed care quality strategy and continue best practices identified in DSRIP.

Determination of rate and dollar increase:

HHSC will consider several factors in determining the percentage rate increase that will be directed for one or both classes of CMHCs within an SDA, including the amount of available funding; the class or classes of CMHCs eligible to receive the increase; the type of service subject to the increase; budget neutrality; and the actuarial soundness of the capitation payment needed to support the increase.

Reconciliation and recoupment:

HHSC will follow the methodology described in Title 1 of the Texas Administrative Code (TAC), §353.1301 to reconcile the amount of non-federal funds expended under this section and to authorize recoupments of overpayment or disallowance amounts.

COMMENTS

The 15-day comment period ended February 13, 2021.

During this period, HHSC received comments regarding the proposed rules from 15 entities, including Amerigroup, Bluebonnet Trails Community Services, Bell County Indigent Care Program, Child and Family Guidance Center, CHI St. Luke's Health, Colleen Horton- Medical Care Advisory Committee, Emergence Health Network, Hamilton Healthcare System, North Texas Behavioral Health Authority, Palms Behavioral Health, Southern Area Behavioral Healthcare Services, Texas Association of Health Plans, Texas Council of Community Centers, Universal Health Services, and University of Texas Medical Branch. A summary of the comments received and HHSC's responses follows.

Definitions:

Comment: One commenter recommended minor changes to the definition of a CMHC to more closely align with current statutory and contractual requirements for CMHCs, terminology used by the behavioral health community, and terminology used elsewhere in the Texas Administrative Code.

Response: HHSC agrees with some, but not all, of this commenter's recommended changes to the definition of a CMHC §353.1320(4). HHSC made the changes that aligned the definition with the definition of CMHC services as specified in 42 U.S.C. § 300x-2(c)(1).

Data sources for historical units of service:

Comment: One commenter indicated that the term "encounter" is defined at §353.2(35) as "A covered service or group of covered services delivered by a provider to a member during a visit between the member and provider. This also includes value-added services." The commenter indicated that this definition relies on the word "visit," which could be interpreted as in-person only. They recommended a broad interpretation of an encounter (or visit) to include all authorized modes of service delivery.

Response: HHSC disagrees with the comment. The rule refers to "encounter data," defined in the Uniform Managed Care Contract (UMCC) as "a representation of a claim received and adjudicated by an MCO without alteration or omission." The rule is not referring to an encounter as defined in §353.2(35). No changes were made in response to this comment.

Directed Payment Program for Behavioral Health Services (DPP BHS) eligibility and application process:

Comment: One commenter asked if an entity that is not yet a CMHC could participate in the DPP BHS.

Response: Only CMHCs may participate in the DPP BHS. A CMHC is defined in §353.1320(b)(4) as an entity that is established under Texas Health and Safety Code §534.0015 and that: (A) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals with serious mental illness, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility; (B) Provides 24-hour-a-day emergency care services; (C) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services; and (D) Provides screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. No changes were made in response to this comment.

Comment: One commenter asked if a hospital-based behavioral health clinic that is not a CMHC could participate in the DPP BHS.

Response: Only CMHCs may participate in the DPP BHS. A CMHC is defined in §353.1320(b)(4) as an entity that is established under Texas Health and Safety Code §534.0015 and that: (A) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals with serious mental illness, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility; (B) Provides 24-hour-a-day emergency care services; (C) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services; and (D) Provides screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. No changes were made in response to this comment.

Comment: Several commenters requested that local behavioral health authorities (LBHAs), specifically the North Texas Behavioral Health Authority (NTBHA), be allowed to participate in DPP BHS. They argue that LBHAs provide the same state mandated mental health services as CMHCs and therefore it is unfair to exclude LBHAs that are not CMHCs from DPP BHS.

Response: DPP payments are administered through Medicaid managed care to advance quality objectives of the state's Medicaid Managed Care Quality Strategy. There are currently not any non-CMHC LBHAs that are in-network Medicaid managed care providers with claims history eligible for incorporation into the program or cost modeling. HHSC will consider amending the program rules in the future to incorporate LBHAs that are enrolled providers with Medicaid managed care organizations. No changes were made in response to this comment.

Comment: One commenter noted that outpatient services provided by CMHCs are eligible for the directed payments in the DPP BHS and requested that HHSC also provide directed payments to institutions for mental disease (IMDs) for the provision of outpatient services.

Response: Eligibility for DPP BHS is limited to CMHCs. Outpatient services provided by an IMD are eligible for increased reimbursement under the Comprehensive Hospital Increased Reimbursement Program (CHIRP), a directed payment program for hospitals. No changes were made in response to this comment.

Comment: One commenter requested clarification on the DPP BHS application process. Specifically, they asked how the application process for CMHCs that are already certified as CCBHCs will differ from the application process for CMHCs that are not certified as CCBHCs.

Response: The DPP BHS application process for all CMHCs will be the same. CMHCs will need to indicate the current status as a CCBHC or not. No changes were made in response to this comment.

Classes of participating CMHCs:

Comment: One commenter expressed concern that HHSC could be penalizing CMHCs that do not have the resources to become certified CCBHCs, thereby exacerbating disparities in the healthcare system by directing a higher uniform percentage rate increase or uniform dollar increase to CMHCs that are certified CCBHCs than to CMHCs that are not certified CCBHCs.

Response: DPP BHS is intended to incentivize CMHCs to earn and maintain their CCBHC certification. The five percent differential in the rate enhancement of the quality component of the program is intended to provide that incentive. HHSC has factored into the CCBHC cost-report financial modeling a projected cost growth of 10 percent for CMHCs that were not yet certified in state fiscal year 2019. In essence, the enhanced rate in DPP BHS for non-certified CMHCs already assumes the higher cost for the work toward meeting the certification requirements. HHSC believes that this balanced approach recognizes efforts of both types of CMHCs - those that have already achieved certification as a CCBHC and those that are still going through this process. No changes were made in response to this comment.

Distribution of DPP BHS payments:

Comment: One commenter asked how Component Two payments would be made to CMHCs. The commenter asked if the payments are claims-based, and if the amount of the enhancement to these payments calculated based on historical utilization will be paid out on actual utilization. The commenter also wanted to clarify if the actual utilization payment process would allow an individual CMHC to exceed the 35 percent available to it and if it would create a competition among CMHCs for the 35 percent of Component Two funding with the possibility that the overall 35 percent cap on Component Two can be exceeded.

Response: The total available funding is an estimated model based on historical utilization. The amount of Component Two payments will be paid out on actual utilization as MCOs adjudicate the claims; at this time there is no cap. CMS expects there to be an element of risk in a DPP; the premiums to Medicaid MCOs also reflect this risk by including a risk margin, in addition to other administrative and tax costs. It is assumed that

MCOs would continue to manage utilization, and any variation in utilization would be limited. In addition, HHSC will be monitoring service utilization to determine if additional program adjustments are needed, such as the inclusion of a cap on a specific component. No changes were made in response to this comment.

Comment: One commenter asked if the rate enhancements for Component Two are contingent upon a CMHC meeting all required metrics such that there is an all-or-none requirement associated with the enhanced rate payments.

Response: The measures and reporting requirements including performance requirements will be addressed annually through the public hearing referenced in §353.1322(e). No changes were made in response to this comment.

Comment: One commenter asked if the enhanced value for each allowed service is calculated so that it is the same percentage increase for every CMHC and the same for each allowed service.

Response: Component One provides a uniform dollar increase per historical unit of service for each CMHC enrolled in the program. Component Two is a uniform percentage increase for each of the top 15 CCBHC procedure codes. The percentage increase is the same per service within the provider class. No changes were made in response to this comment

Comment: One commenter asked HHSC to discontinue the practice of using the MCO's claims 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 claims system is paramount to avoid downstream confusions. The commenter asked HHSC to replicate the Quality Incentive Payment Program (QIPP) in a similar way for DPP BHS. 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.

Response: 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. No changes were made in response to this comment

Non-federal share of program payments:

Comment: One commenter requested confirmation that the statement in §353.1320(j) that "no state general revenue is available to support the Directed Payment Program for Behavioral Health Services" means that no state general revenue that is not otherwise available to CMHCs is available to support DPP BHS. The commenter indicated they anticipate CMHCs will have authority to use allocated state general revenue as IGT for DPP BHS, as they do today in the DSRIP program, and requested that HHSC make any conforming changes to the rule necessary to ensure CMHCs are able to use allocated state general revenue as IGT for DPP BHS.

Response: The provision "no state general revenue is available to support the Directed Payment Program for Behavioral Health Services" means that no state general revenue is appropriated to HHSC specifically for this program. CMHCs may use permissible public funds, including state general revenue that may be received by CMHCs, as IGT for DPP BHS. HHSC has modified §353.1320(j) to make this clarification.

Comment: One commenter recommended that HHSC revise §353.1320(j)(3) to reflect that required IGT amounts will include only the non-federal share of all costs associated with the CMHC rate increase, including costs associated with MCO (Capitation) premium taxes, risk margin, and administration, plus 10 percent.

Response: HHSC agrees with this comment and has modified §353.1320(j)(3) to reflect that required IGT amounts will include only the non-federal share of these costs.

Comment: One commenter requested clarification regarding the 10 percent component of IGT amounts specified in §353.1320(j)(3). The commenter asked what the purpose of collecting the additional 10 percent is and how the 10 percent is calculated. For example, is it 10 percent of all costs associated with the CMHC rate increase or 10 percent of a subset of the items listed in §353.1320(j)(3)? The commenter expressed concern this expectation will diminish a CMHC's ability to deliver on outcomes required in DPP BHS.

Response: The 10 percent is collected by HHSC as the amount above the estimated total IGT needed to support the program. Directed-payment programs are operated by committing to a monthly per member per month increase to MCOs and the actual amount of the program can vary from estimates, if actual caseloads experienced deviate from the forecasted amount. The additional IGT collected is maintained as a buffer in the event that caseloads exceed expectations and may be returned to the unit of local governments in accordance with the reconciliation process described in §353.1301. No changes were made in response to this comment.

Quality metrics:

Comment: One commenter recommended aligning DPP BHS measures with current MCO and Alternative Payment Model (APM) measures to avoid further confusing or frustrating providers. The commenter also recommended aligning DPP BHS measures with the same P4Q measures that MCOs are financially at risk to achieve.

Response: The measures and reporting requirements including performance requirements will be addressed annually through the public hearing referenced in §353.1322(e). No changes were made in response to this comment.

Comment: One commenter requested that HHSC consider removing metrics that MCOs use to manage APM requirements from those MCOs' contracts in order to prevent a provider from being paid twice for the same metrics. The commenter indicated that this is a structural issue around the current UMCC.

Response: The measures and reporting requirements including performance requirements will be addressed annually through the public hearing referenced in §353.1322(e). No changes were made in response to this comment.

MCOs:

Comment: One commenter requested clarification on: 1) the timing of when HHSC will provide the MCOs with the payment calculations for the prospective monthly payments to the CMHCs; 2) the impact of any reconciliation on MCOs; 3) how HHSC will communicate the different classes to the MCOs; 4) the type of data and reporting required by HHSC and how HHSC and the MCOs will exchange data; 5) how HHSC will work with

the MCOs, understanding the various claims systems, and the time it may take to make required claims system modifications; 6) expectations related to agreements with providers and how these arrangements will impact existing provider contracts; and 7) if and how HHSC will work with the Texas Department of Insurance to waive the risk-based capital requirements on these funds, given the MCOs lack control over the expenditure of these funds and will likely be required to track them as separate and distinct funds.

Response: HHSC has established a workgroup with representatives from MCOs and will address these operational questions through the workgroup process. No changes were made in response to this comment.

General:

Comment: One commenter indicated they strongly support DPP BHS.

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

Comment: One commenter indicated they appreciate the proposed rule recognizes that current Medicaid payments to CMHCs may not cover all costs of comprehensive, CCBHC services. That said, their experience tells them the "may not cover" reference in the preamble could, with confidence, be changed to, "do not cover" all costs of CCBHC services.

Response: HHSC declines to make the suggested change.

Comment: One commenter asked if a CMS extension of the enhanced Federal Medical Assistance Percentage (FMAP) by six percent would apply to the CMHCs participating in the first year of DPP BHS.

Response: The enhanced FMAP will apply to DPP BHS until the last day of the calendar quarter in which the last day of the public health emergency occurs. No changes were made in response to this comment.

Comment: One commenter asked how DPP BHS might affect providers' work with MCOs to establish alternative payment models and whether DPP BHS might delay this work.

Response: Under the rule, HHSC will direct an MCO in a participating SDA to increase the rate that it would otherwise pay a CMHC for providing certain services. HHSC does not believe the rule precludes the parties contracting to use an alternative payment model for the services subject to the rate increase, as long as payment to the CMHC for the subject services is increased by the designated percentage. However, because it is a uniform rate increase to what would otherwise be paid for the subject services, the MCO and CMHC may not develop an alternative payment model that is applied only to the increase in the capitation payment to the MCO. In other words, the alternative payment model must apply to the complete payment for the service, not just to the portion of the payment added under this rule.

No changes were made to the rule in response to this comment. However, HHSC welcomes continued dialogue with MCOs and CMHCs to gain insight into the impact of DPP BHS on efforts to develop alternative payment models. HHSC will consider amending the rule in the future if necessary to facilitate alternative payment models.

Comment: One commenter asked if there "is a program in place that is being looked into for uninsured patient care OUTSIDE of the Community Provider Program."

Response: This does not appear to be a comment on the proposed rules, and it is unclear what sort of program for uninsured patient care the commenter is asking about. However, directed payment programs such as DPP BHS only apply to Medicaid managed care. No changes were made to the rules in response to this comment.

Comment: One commenter asked how they could incorporate this program into jail health if possible.

Response: This does not appear to be a comment on the proposed rules, and it is unclear what the commenter means regarding "jail health." No changes were made to the rules in response to this comment.

HHSC made minor grammatical edits to §353.1320(c)(2), §353.1320(f)(2)(D), and §353.1322(e)(1)(A). HHSC also renumbered §353.1320(b)(5) to §353.1320(b)(6), and §353.1320(b)(6) to §353.1320(b)(8).

HHSC made minor editorial changes to §353.1320(a) by adding the program abbreviation DPP BHS; to §353.1320(e)(1) by updating the final enrollment period from "at least nine days prior to IGT notification" to "at least nine days prior to the release of suggested IGT responsibilities"; to §353.1320(i)(1)(A) by changing "provider" to "CMHC"; to §353.1320(j) and §353.1320(j)(1) by replacing "program" with "DPP BHS"; to §353.1320(j)(1) by changing "share" to "communicate"; to §353.1320(j)(2)(A) by changing "wishes" to "intends"; to §353.1320(j)(4) by updating "HHSC Provider Finance webpage" to "its Internet website"; to §353.1320(l) by adding "Provider Finance Department" after "HHSC"; to §353.1322(d)(3) by replacing "Achievement will be" with "CMHCs must" and adding "quality metric achievement"; and to §353.1322(e)(1) by inserting "quality" before "metrics" and deleting "of the calendar year that".

HHSC made editorial changes to §353.1320(b) to include definitions for the terms "intergovernmental transfer (IGT) notification" and "suggested IGT responsibility". HHSC added new §353.1320(d)(6) to specify that only certain encounter data will be used in calculating DPP BHS payments. Encounter data used to calculate DPP BHS payments must be designated as paid status with a reported paid amount greater than zero. Encounters reported as paid status, but with a reported paid amount of zero or negative dollars, will be excluded from the data used to calculate DPP BHS payments so that the calculations will not be inappropriately skewed. HHSC amended §353.1320(e)(2) to specify that no part of any DPP BHS payment will be used to pay a contingent fee, nor may the entity's agreement with the CMHC 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 CMHC's receipt of DPP BHS funds, and the certification must be received by HHSC with the enrollment application. Also, as HHSC does not wish to impose significant administrative burdens or to infringe upon third parties' relationships to which no governmental entity is a party, HHSC amended §353.1320(e)(3) to make the requirement to submit copies of contracts with third parties to HHSC specific to instances where a change of ownership has occurred that would impact the CMHC's eligibility for DPP BHS.

HHSC also made editorial changes to §353.1320(j)(1) by deleting "plus estimated utilization for eligible and enrolled within the same SDA" and "The purpose of sharing this information is to provide CMHCs with information they can use to determine the amount of IGT they wish to transfer"; to §353.1320(j)(2)

and §353.1320(j)(4) by changing "CMHCs" to "sponsoring governmental entities"; to §353.1320(j)(2) by changing "15 business days" to "21 business days" to ensure CMHCs have adequate time to prepare for the semi-annual IGT transfer; and to §353.1320(j)(3) by adding language that 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 to ensure CMHCs have adequate time to prepare for the semi-annual IGT transfer; to §353.1322(c)(1) by replacing "pay-for-reporting (P4R)" with "improvement over self (IOS)" and changing "pay for performance (P4P)" to "benchmark"; to §353.1322(d)(2)(A) by updating "The achievement of a structure measure is tested on whether a CMHC meets the established requirement" to "To achieve a structure measure a CMHC must report its progress on associated activities for each measurement period"; to §353.1322(d)(2)(B) by replacing P4R with an IOS or benchmark measure and deleting "is based on reporting data for a specified measurement period"; and to §353.1322(d)(2)(C) by deleting "The achievement of a P4P measure is based on meeting" and adding "a target percentage" and "In year one of the program, achievement of an IOS measure will be establishing a baseline".

STATUTORY AUTHORITY

The new sections are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code, Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

§353.1320. Directed Payment Program for Behavioral Health Services.

(a) Introduction. This section establishes the Directed Payment Program for Behavioral Health Services (DPP BHS). DPP BHS is designed to incentivize community mental health centers (CMHCs) to improve quality, access, and innovation in the provision of medical and behavioral health 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) or §353.1322 of this subchapter (relating to Quality Metrics for the Directed Payment Program for Behavioral Health Services).

(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) Certified community behavioral health clinic (CCBHC)--A clinic certified by the state in accordance with federal criteria and with the requirements of the Protecting Access to Medicare Act of 2014 (PAMA).

(3) CCBHC cost-reporting gap--The difference between what Medicaid pays for services and what the reimbursement would be based on the CCBHC cost-reporting methodology.

(4) Community mental health center (CMHC)--An entity that is established under Texas Health and Safety Code §534.0015 and that:

(A) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals with serious mental illness, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility.

(B) Provides 24-hour-a-day emergency care services.

(C) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(D) Provides screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission.

(5) Intergovernmental transfer (IGT) notification--Notice and directions regarding how and when IGTs should be made in support of DPP BHS.

(6) Program period--A period of time for which the Texas Health and Human Services (HHSC) contracts with participating managed care organizations (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. A CMHC that is unable to participate in the program described in this section beginning September 1 may apply to participate beginning March 1 of the program period and ending August 31. Participation during such a modified program period is subject to the application and intergovernmental-transfer (IGT) deadlines described in subsection (j) of this section.

(7) Suggested IGT responsibility--Notice of potential amounts that a sponsoring governmental entity may wish to consider transferring in support of DPP BHS.

(8) Total program value--The maximum amount available under the Directed Payment Program for Behavioral Health Services for a program period, as determined by HHSC.

(c) Classes of participating CMHCs.

(1) HHSC may direct the MCOs to provide a uniform percentage rate increase or a uniform dollar increase to all CMHCs within one or more of the following classes of CMHCs with which the MCO contracts for services:

(A) CMHCs that are certified CCBHCs; and

(B) CMHCs that are not certified CCBHCs.

(2) If HHSC directs rate or dollar increases to more than one class of CMHCs within the service delivery area (SDA), the rate or dollar increases directed by HHSC may vary between classes.

(d) Data sources for historical units of service. Historical units of service are used to determine the estimated distribution of program funds across eligible and enrolled CMHCs.

(1) HHSC will use encounter data and will identify encounters based upon the billing provider's national provider identification (NPI) number.

(2) The most recently available Medicaid encounter data for a complete state fiscal year will be used to determine the distribution of program funds across eligible and enrolled CMHCs.

(3) In the event that the historical data are not deemed appropriate for use by actuarial standards, HHSC may use data from a different state fiscal year at the discretion of the HHSC actuaries.

(4) The data used to estimate distribution of funds will align to the extent possible with the data used for purposes of setting the capitation rates for MCOs for the same period.

(5) HHSC will calculate the estimated rate that an average commercial payor or Medicare would have paid for similar services or based on the CMS approved CCBHC cost report rate methodology using either data from Medicare cost reports or collected from providers.

(6) Encounter data used to calculate DPP BHS payments must be designated as paid status with a reported paid amount greater than zero. Encounters reported as paid status, but with a reported paid amount of zero or negative dollars, will be excluded from the data used to calculate DPP BHS payments.

(e) Participation requirements. As a condition of participation, all CMHCs participating in the program must allow for the following.

(1) The CMHC 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 calendar days prior to the release of suggested IGT responsibilities.

(2) The entity that bills on behalf of the CMHC must certify, on a form prescribed by HHSC, that no part of any payment made under the program will be used to pay a contingent fee and that the entity's agreement with the CMHC 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 CMHC's receipt of program 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 DPP BHS, 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, DPP BHS.

(f) Determination of percentage of rate and dollar increase.

(1) HHSC will determine the percentage of rate or dollar increase applicable to CMHC by program component.

(2) HHSC will consider the following factors when determining the rate increase:

(A) the estimated Medicare gap for CMHCs, based upon the upper payment limit demonstration most recently submitted by HHSC to the Centers for Medicare and Medicaid Services (CMS);

(B) the estimated Average Commercial Reimbursement (ACR) gap for the class or individual CMHCs, as indicated in data collected from CMHCs;

(C) the estimated gap for CMHCs, based on the CCBHC cost-reporting methodology that is consistent with the CMS guidelines;

(D) the percentage of Medicaid costs incurred by CMHCs in providing care to Medicaid managed care clients that are reimbursed by Medicaid MCOs prior to any rate increase administered under this section; and

(E) the actuarial soundness of the capitation payment needed to support the rate increase.

(g) Services subject to rate and dollar increase. HHSC may direct the MCOs to increase rates or dollar amounts for all or a subset of CMHC services.

(h) Program capitation rate components. Program funds will be paid to MCOs through two components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of program funds to the enrolled CMHCs will be based on each CMHC's performance related to the quality metrics as described in §353.1322 of this subchapter. The CMHC must have provided at least one Medicaid service to a Medicaid client for each reporting period to be eligible for payments.

(1) Component One.

(A) The total value of Component One will be equal to 65 percent of total program value.

(B) Allocation of funds across all qualifying CMHCs will be proportional, based upon historical Medicaid utilization.

(C) Monthly payments to CMHCs will be triggered by achievement of requirements as described in §353.1322 of this subchapter.

(D) The interim allocation of funds across qualifying CMHCs will be reconciled to the actual Medicaid utilization across these CMHCs during the program period, as captured by Medicaid MCOs contracted with HHSC for managed care 180 days after the last day of the program period. This reconciliation will only be performed if the absolute values of percentage changes between each CMHC's proportion of historical Medicaid utilization and actual Medicaid utilization is greater than 10 percent.

(2) Component Two.

(A) The total value of Component Two will be equal to 35 percent of total program value.

(B) Allocation of funds across all qualifying CMHCs will be based upon historical Medicaid utilization.

(C) Payments to CMHCs will be triggered by achievement of performance requirements as described in §353.1322 of this subchapter.

(3) Non-disbursed funds. Funds that are non-disbursed due to failure of one or more CMHCs to meet performance requirements will be distributed across all qualifying CMHCs based on each CMHC's proportion of total earned program funds from Components One and Two combined at the end of the year.

(i) Distribution of the Directed Payment Program for Behavioral Health Services payments.

(1) Prior to the beginning of the program period, HHSC will calculate the portion of each payment associated with each enrolled CMHC broken down by program capitation rate component, quality metric, and payment period. For example, for a CMHC, HHSC will calculate the portion of each payment associated with that CMHC that would be paid from the MCO to the CMHC as follows.

(A) Monthly payments in the form of a uniform dollar increase for Component One will be equal to the total value of Component One attributed based upon historical utilization of the CMHC divided by twelve.

(B) Ongoing rate increases from Component Two will be paid as performance requirements are met and will be a uniform percentage rate increase on applicable services calculated based on the total value of Component Two for the CMHCs divided by historical utilization of the respective services.

(C) For purposes of the calculation described in subparagraph (B) of this paragraph, a CMHC must achieve a minimum

number of measures as identified in §353.1322 of this subchapter to be eligible for full payment.

(2) MCOs will distribute payments to enrolled CMHCs based on criteria established under paragraph (1) of this subsection.

(j) Non-federal share of DPP BHS payments. The non-federal share of all DPP BHS payments is funded through IGTs from sponsoring governmental entities. No state general revenue that is not otherwise available to CMHCs is available to support DPP BHS.

(1) HHSC will communicate suggested IGT responsibilities for the program period with all DPP BHS eligible and enrolled CMHCs at least 10 calendar days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars available under DPP BHS for the program period as determined by HHSC, plus 10 percent; forecasted member months for the program period as determined by HHSC; and the distribution of historical Medicaid utilization across CMHCs, for the program period. HHSC will also communicate estimated maximum revenues each eligible and enrolled CMHC could earn under DPP BHS for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled CMHCs will meet 100 percent of their quality metrics.

(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 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. HHSC will instruct sponsoring governmental entities as to the IGT amounts necessary to fund the program at estimated levels. IGT amounts will include the non-federal share of all costs associated with the CMHC rate increase, including costs associated with MCO (Capitation) premium taxes, risk margin, and administration, plus 10 percent.

(4) 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 by March 15 of each year.

(k) Effective date of rate and dollar reimbursement increases. HHSC will direct MCOs to increase reimbursements 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.

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

(m) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each 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 and, as applicable, subsection (h)(1)(D) of this section.

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

§353.1322. Quality Metrics for the Directed Payment Program for Behavioral Health Services.

(a) Introduction. This section establishes the quality metrics and required reporting that may be used in the Directed Payment Program for Behavioral Health Services.

(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 (relating to General Provisions) or §353.1320 (relating to Directed Payment Program for Behavioral Health Services) of this subchapter.

(1) Baseline--An initial standard used as a comparison against performance in each metric throughout the program period to determine progress in the program's quality metrics.

(2) Benchmark--A metric-specific initial standard set prior to the start of the program period and used as a comparison against a community mental health center's (CMHC's) progress throughout the program period.

(3) Measurement period--The time period used to measure achievement of a quality metric.

(c) Quality metrics. For each program period, the Texas Health and Human Services Commission (HHSC) will designate quality metrics for each of the program's capitation rate components as described in §353.1320(h) of this subchapter.

(1) Each quality metric will be identified as a structure measure, improvement over self (IOS) measure, or benchmark measure.

(2) Each quality metric will be evidence-based and will be presented to the public for comment in accordance with subsection (e) of this section.

(d) Performance requirements. For each program period, HHSC will specify the performance requirement that will be associated with the designated quality metric that is expected to advance at least one of the goals and objectives in the Medicaid quality strategy. Achievement of performance requirements will trigger payments for the program's capitation rate components as described in §353.1320(h) and be used 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 §353.1320(h) of this subchapter. For some quality metrics, achievement is tested merely on whether a CMHC meets or does not meet the established requirement. The following performance requirements are associated with the quality metrics described in subsection (c) of this section.

(1) Reporting of quality metrics. All quality metrics must be reported for the CMHC to be eligible for payment.

(2) Achievement of quality metrics.

(A) To achieve a structure measure, a CMHC must report its progress on associated activities for each measurement period.

(B) To achieve an IOS or benchmark measure, a CMHC must meet or exceed the measure's goal for a measurement period.

Goals will be established as either a target percentage improvement over self or performance above a benchmark as specified by the metric and determined by HHSC. In year one of the program, achievement of an IOS measure will be establishing a baseline.

(3) Reporting frequency. CMHCs must report quality metric achievement semi-annually, unless otherwise specified by the metric.

(4) Other metrics related to improving the quality of care for Texas Medicaid beneficiaries. If HHSC develops additional metrics for inclusion in the Directed Payment Program for Behavioral Health Services, the associated performance requirements will be presented to the public for comment in accordance with subsection (e) of this section.

(e) Notice and hearing.

(1) HHSC will publish notice of the proposed quality metrics and their associated performance requirements no later than January 31 preceding 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 for 15 business days following publication. There will also be a public hearing within that 15-day period to allow interested persons to present comments on the proposed metrics and performance requirements.

(f) Publication of final metrics and performance requirements. Final quality metrics and performance requirements will be provided through HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period. If the Centers for Medicare and Medicaid Services requires changes to quality metrics or performance requirements after February 28 of the calendar year but before the first month of the program period, HHSC will provide notice of the changes through HHSC's website.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 1, 2021.

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Karen Ray
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Texas Health and Human Services Commission
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TITLE 34. PUBLIC FINANCE

PART 6. TEXAS MUNICIPAL RETIREMENT SYSTEM

CHAPTER 125. ACTIONS OF PARTICIPATING MUNICIPALITIES

The Board of Trustees (Board) of the Texas Municipal Retirement System (TMRS or the System) adopts the repeal of current 34 TAC Chapter 125 (Chapter 125) relating to actions of participating municipalities, as published in the December 25, 2020, issue of the *Texas Register* (45 TexReg 9387). The repeals will not be republished.

TMRS repeals the following rules: 34 TAC §125.1, Optional Vesting Must Include All Departments; 34 TAC §125.2, Composite Participating Date Requires Council Action; 34 TAC §125.3, Actuary Determines Contribution Rates; 34 TAC §125.4, Effect of Adopting Composite Participating Date; 34 TAC §125.5, When Composite Participating Date Must Be Adopted; 34 TAC §125.6, Limitations on Buy-Back Ordinances; 34 TAC §125.7, Optional Additional Contributions to Benefit Accumulation Fund.

The Board of TMRS adopts new Chapter 125, relating to actions of participating municipalities §§125.1 - 125.11, without changes to the proposed text as published in the December 25, 2020, of the *Texas Register* (45 TexReg 9389). These rules will not be republished. TMRS adopts the following rules: 34 TAC §125.1, Optional Vesting Must Include All Departments; 34 TAC §125.2, Composite Participating Date Requires Council Action; 34 TAC §125.3, Effect of Adopting Composite Participating Date; 34 TAC §125.4, When Composite Participating Date Must Be Adopted; 34 TAC §125.5, Limitations on Buy Back Ordinances; 34 TAC §125.6, Optional Additional Contributions to Benefit Accumulation Fund; 34 TAC §125.7, Elected Officials; 34 TAC §125.8, Collection of Contributions; 34 TAC §125.9, Correction of Errors; 34 TAC §125.10, Ordinances; 34 TAC §125.11, Use of City Portal System.

BACKGROUND AND PURPOSE

New Chapter 125 is adopted to update, modernize, and provide clarification to its rules relating to actions of participating municipalities under existing benefit plans of TMRS. Statutes specific to TMRS are found in Title 8, Subtitle G, Chapters 851 through 855, Texas Government Code (the "TMRS Act"). In addition, the repeal and replacement of Chapter 125 is adopted as a result of TMRS' rule review, which was conducted pursuant to Texas Government Code §2001.039.

Five new Chapter 125 rules in 34 TAC §125.1, Optional Vesting Must Include All Departments; 34 TAC §125.2, Composite Participating Date Requires Council Action; 34 TAC §125.3, Effect of Adopting Composite Participating Date; 34 TAC §125.4, When Composite Participating Date Must Be Adopted; and, 34 TAC §125.6, Optional Additional Contributions to Benefit Accumulation Fund have been renumbered but are otherwise unchanged from prior rules. One adopted rule for Chapter 125 (in 34 TAC §125.5, Limitations on Buy Back Ordinances) is amended to add one word for clarity. Substantive changes, however, are adopted in the form of five additional new rules, which are described as follows: clarify documentation that TMRS may request regarding the eligibility of elected officials to participate in the System pursuant to §852.107 of the TMRS Act (in §125.7); clarify duties under the TMRS Act (including, but not limited to, §855.402) regarding the collection and receipt of payroll reports and member and employer contributions, and provide for cities to submit electronic payments to TMRS, unless otherwise excepted by the proposed rule (in §125.8); clarify processing of error corrections regarding service credits, contributions and payments under applicable federal and state laws and Internal Revenue Service guidance (in §125.9); clarify deadlines for ordinances not otherwise specified in the TMRS Act and delegate to the TMRS Executive Director authority to approve ordinances regarding certain bene-

fits, Cost of Living Adjustments and Updated Service Credits (in §125.10); and, clarify terms and conditions under which participating cities may use the System's electronic city portal system (in §125.11).

Current rule §125.3, Actuary Determines Contribution Rates, is being repealed as it is no longer necessary for the administration of the System.

No comments were received regarding the adoption of the repeal and new Chapter 125.

34 TAC §§125.1 - 125.7

STATUTORY AUTHORITY

The repeal of existing Chapter 125 is adopted under the following provisions of the TMRS Act or the Texas Government Code: (i) Government Code §855.102, which allows the Board to adopt rules it finds necessary or desirable for the efficient administration of the System; and, Government Code §2001.039 which grants the Board the authority to review and repeal rules after assessment of whether the reasons for initially adopting the rule continue to exist.

CROSS-REFERENCE TO STATUTES

Texas Government Code: §§802.1024, 802.1025, 852.005, 852.107, 853.003, 853.403, 854.203, 855.402, and 855.403.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Christine M. Sweeney
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Texas Municipal Retirement System
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For further information, please call: (512) 225-3710

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34 TAC §§125.1 - 125.11

The new Chapter 125 rules are adopted pursuant to the authority granted under the following provisions of the TMRS Act or the Texas Government Code: (i) Government Code §855.102, which allows the Board to adopt rules it finds necessary or desirable for the efficient administration of the System; and, (ii) Government Code §855.201, which allows the Board to delegate to the executive director powers and duties provided to the Board by the TMRS Act. In addition, the rule changes are adopted as a result of TMRS' rule review, which was conducted pursuant to Texas Government Code §2001.039.

CROSS-REFERENCE TO STATUTES

Texas Government Code: §§802.1024, 802.1025, 852.005, 852.107, 853.003, 853.403, 854.203, 855.402, and 855.403.

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