UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

THE STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Plaintiffs,

v.

CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services, et al.

Defendants.

Case No.: 1:21-cv-00191

DECLARATION OF JOHN GILES

I, John Giles of the Center for Medicaid and CHIP Services (CMCS) at the Centers for Medicare & Medicaid Services (CMS), declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the ordinary course of my duties.

1. I am employed by the Department of Health and Human Services (HHS) in CMCS at CMS, located at 7500 Security Boulevard, Baltimore, MD 21244. I have held the following positions at CMS:

Director of the Division of Managed Care Policy, April 2020 – Present

Senior Policy Advisor, August 2019 – November 2019

Technical Director/Health Insurance Specialist, June 2016 – August 2019

Health Insurance Specialist, November 2014 – June 2016

2. CMCS is a component of CMS. It is charged with administering the Medicaid program and serves as CMS's focal point for assistance with formulation, coordination, integration, and implementation of all national program policies and operations relating to Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP). CMCS works in partnership with states, assists state agencies in successfully carrying out their responsibilities for effective program administration and protecting beneficiaries, and, as necessary, supports states in correcting problems and improving the quality of their operations. CMCS also identifies and proposes modifications to program measures; regulations; laws; and policies to reflect changes or trends in the health care industry, program objectives, and beneficiaries' needs.

3. As the Director for the Division of Managed Care Policy (DMCP) within the Center for Medicaid and CHIP Services (CMCS) at the Centers for Medicare & Medicaid Services (CMS), I manage the Medicaid managed care policy activities across four primary portfolios of work, including Medicaid managed care policy development, delivery system and provider payment initiatives (state directed payments or SDPs), capitation rate development, and Medicaid managed care risk mitigation and medical loss ratios (MLRs).

4. The Division of Managed Care Policy (DMCP) is responsible for all Medicaid managed care policy activities for CMCS. The division includes 22 full-time employees that conduct work across four primary teams, including: (1) State Policy (focused on federal Medicaid managed care authorities, policy technical assistance for states, federal policy development, and Medicaid managed care policy associated with the Mental Health Parity and Addiction Equity Act); (2) Rate Development (focused on federal Medicaid managed care

standards and requirements for Medicaid managed care capitation rate development); (3) Provider Reimbursement (focused on the review and approval of Medicaid managed care state directed payment proposals, including the management of a federal review team for state directed payments); and (4) Risk Mitigation and Medical Loss Ratios (MLRs) (focused on the review and approval of state risk mitigation strategies and MLRs that are ultimately incorporated into Medicaid managed care contracts and rate certifications).

5. Due to the nature of my official duties, I am familiar with CMS's process for reviewing and approving a state's request to add state directed payments to its Medicaid managed care contracts and rate certifications. I am also part of the federal review team working on Texas's requested state directed payments and have been involved with, among other things, regular meetings with Texas every two business days.

6. We have been meeting with Texas every two business days since shortly after the court's order clarifying sanctions standards on August 12, 2021.

CMS'S PROCESS FOR REVIEWING TEXAS'S STATE DIRECTED PAYMENT REQUESTS

7. When CMS receives a request (via a standardized preprint form) from a state to implement state directed payments in its Medicaid managed care contracts and rate certifications, we convene a federal review team that includes members from CMS's Office of the Actuary (OACT) and several components of CMCS. The makeup of the team depends in part on the nature of the requested state directed payments that are under review, but includes officials from OACT, as well as the following components of CMCS: the Financial Management Group, the Division of Quality and Health Outcomes, the Division of Managed Care Policy, and the Division of Managed Care Operations. That federal review team tasked with reviewing Texas's requested state directed payments also includes officials from another component of CMCS: the State Demonstrations Group.

8. The federal review team must work together and with the state to assess its proposal(s), gather any information necessary to determine whether the request is approvable, and make any modifications to the preprint(s) necessary to satisfy applicable statutory and regulatory requirements, to advance the objectives of the state's Medicaid program, and to advance the overall purposes of Medicaid.

9. On August 13, 2021, we sent a letter to Texas identifying five categories of statutory or regulatory flaws with the SDPs as proposed by Plaintiffs which prevented those proposals from being considered approvable. We also offered to approve a temporary extension application for Texas's Delivery System Reform Incentive Payment program and offered two options for specific modifications Texas could make to its state directed payments to permit CMS to approve them. CMS believed at the time of the August 13th letter that it could determine that the actuarial soundness issues wouldn't apply because the previously approved QIPP and UHRIP did not present the same the aggregate funding and year-over-year increase issue. Under Option #1 in the August 13 letter, we were holding the state to the same uniform payment increases as CMS had previously approved in SFY 2021. Additionally, CMS was willing to permit Texas to resolve certain issues in the future, including the utilization, quality, and evaluation issues remaining in QIPP, which the state has subsequently addressed and CMS has approved. While there was risk that the non-federal share of UHRIP payments would be funded, in part, through non-federal share of LPPF arrangements that included hold-harmless arrangements, CMS was at the time still actively collecting information from the state regarding the specifics of the arrangements and reviewing the available information internally. Additionally, the total size of the UHRIP state directed payment was substantially smaller than the three state directed payments that presented the same financing issue in Texas's pending

request. That smaller size made it more feasible for CMS to approve the UHRIP payment and later seek disallowances if further factfinding confirmed that it was funded using an impermissible source of the non-federal share.

10. We have been meeting with Texas every two business days since August 18, 2021. CMS's federal review team has been actively engaged in discussions with Texas during those meetings. Between meetings, we exchange emails with Texas to set the agenda for the following meeting, to continue discussions that began in the previous meeting, and occasionally to provide a written record of statements made during the previous meeting. I have spent substantial time preparing for the meetings with Texas and following up on action items discussed during the course of those meetings, and I know my CMS colleagues have done so as well.

11. Our normal workload for state directed payment reviews typically consists of approximately 100 preprints under review at any one time, from approximately 40 states. The federal review team usually takes 2 to 3 weeks to review each preprint form and states' responses to CMS's question sets and to respond to those submissions with additional requests for information or modifications. With Texas, despite our obligations to respond to questions from other states, we prioritized our work with Texas above other states and have provided written feedback as quickly as possible and in any event within 20 calendar days of receiving responses from Texas, and we met with the state every two business days. Each of Texas's state directed payments also contains multiple components making them more complex and time consuming to respond to.

12. The parties first met telephonically to discuss the state directed payments on August 18, 2021. On August 20, 2021, CMS sent Texas a written document outlining specific

modifications needed on Texas's five state directed payments to ensure the payments complied with the Medicaid statute and CMS's regulations.

13. Texas responded to that modification document on August 25. In Texas's response, the state offered to remove the reconciliation threshold for four of its state directed payments, QIPP, TIPPS, RAPPS, and BHS. The state also offered to impose a limit on its CHIRP payments to 90% of the average commercial rate (ACR).

14. CMS sent additional written feedback to Texas on September 10. In that written feedback, CMS was seeking additional information to better understand the state's requested proposal for replacing the reconciliation threshold, the proposed limit on its CHIRP payments at 90% of the ACR, and potential hold harmless agreements associated with the Local Provider Participation Fund (LPPF) as the source of the non-federal share. CMS also provided guidance on the state's evaluation plans, how quality-based payments could be structured to support year-over-year performance improvement (or maintenance), and on the state's oversight plans for examining the underlying sources of the non-federal share that rely on bonds or other debt instruments.

15. Texas responded to that feedback on September 15. In that response, Texas provided additional information explaining its new reconciliation process, clarifying the 90% ACR limit, analyzing the revised uniform increases and reimbursement level analysis, and providing specific details about its evaluation plans for the state directed payments (including more provider-reported measures and one evaluation to be used for four of the new state directed payments).

16. CMS sent further written follow up questions to Texas on September 24. In that feedback, CMS posed additional questions about the reimbursement level analysis for CHIRP,

how the payments that include the new reconciliation process would be incorporated into the resulting capitation rates, including if those capitation rates would later need to be amended, and about the information the state provided on the LPPFs. CMS also provided additional clarity about the evaluation metrics and targets.

17. Texas responded on September 29 with further modifications to its state directed payments, including changes to its preprints that include the additional information on the payment reconciliation process for four of the state directed payments (QIPP, TIPPS, RAPPS, and BHS) that Texas had included in its previous responses; an explanation that only one of its state directed payments, QIPP, included value-based payment components, and that all other state directed payments would be based on a fee schedule that includes uniform payment increases; changes to its QIPP preprint to add a natural fluctuation margin for Component 3; and changes to its CHIRP preprint to correctly reference the reimbursement analysis.

18. Texas submitted a revised QIPP preprint and evaluation plan to CMS on October 13, 2021. Those revisions included changes to Texas's quality strategy and a description of performance target methodologies for Components 3 and 4 that would apply a fluctuation margin to those components. Texas submitted a combined evaluation plan for CHIRP, TIPPS, RAPPS, and BHS on October 15, 2021, including revised preprints.

19. CMS sent further written feedback and questions to Texas on October 18, 2021. In that feedback, CMS requested that the state confirm details specific to the new reconciliation process, the CHIRP reimbursement level analysis, and the evaluation plans. CMS also requested that the state clarify the total dollar amounts associated with each state directed payment.

20. Texas responded to that feedback on October 22, 2021. In that response, Texas answered CMS's questions about how it would incorporate its state directed payments into the

resulting managed care capitation rates and further explaining its approach to TIPPS Component 1.

21. CMS sent further written feedback to Texas on November 10, 2021. That feedback noted that CMS has "no additional concerns or questions about the size of" Texas's CHIRP program. It also included additional questions regarding the financing issues associated with CHIRP, TIPPS, and RAPPS. *See* Ex. A, CMS's Round 5 Feedback to Texas and Responses from Texas (Nov. 15, 2021).

22. As explained more fully below, most of the issues with Texas's proposed SDPs that we identified in the August 13 letter and during the course of our meetings with the state, have been resolved. The only remaining issue is the source of the state's share of its Medicaid payments, which exists for CHIRP, TIPPS, and RAPPS. We have determined that QIPP and BHS are approvable and have informed the state of that fact.

ISSUES CMS HAS IDENTIFIED WITH TEXAS'S STATE DIRECTED PAYMENTS

Texas's Proposed State Directed Payments Appeared to Present Actuarial Soundness Concerns Because of Their Overall Size and the Year-Over-Year Increase

23. In CMS's initial review of Texas's five requested state directed payments, we noted that we did not believe the aggregate funding amount for those five payments was reasonable. We informed Texas that, "CMS does not consider the current aggregate payment amounts to be reasonable and appropriate, and CMS is concerned that the resulting capitation rates are not actuarially sound." Ex. A at 14. During our calls with Texas, state officials have acknowledged "CMS' concern about the total aggregate funding amount of [state directed payment] funding" and indicated that discussing the actuarial soundness issue was Texas's priority. Ex. B, CMS's Notes from its Meetings with Texas from August 18, 2021, through November 15, 2021, notes from Aug. 18, 2021 & Aug. 20, 2021. CMS explained during our

August 20, 2021 meeting with Texas that OACT has an "overarching concern with the aggregate increase in dollars that would be flowing through managed care capitation rates from one year to the next. If the rates were reasonable and appropriate last year, why would the rates be actuarially sound for this year with new $3B worth of [state directed payments] but without any new populations and services?" *Id.* at 4.

24. To approve state directed payments requested by a state, we must determine that those state directed payments, when incorporated into managed care capitation rates, will result in payments that are consistent with actuarial principles and practices. By Texas's own estimate, its requested state directed payments would result in an increase to its total state directed payments by more than $3 billion over the amount of state directed payments we approved in the previous state fiscal year. And with that increase, Texas's state directed payments would total approximately $7 billion and would comprise approximately 25% of the state's total Medicaid managed care spending.

25. Our concern that Texas's state directed payments were developed in a way that would result in capitation rates that are not actuarially sound was reasonable. If a requested state directed payment represented a significant year-over-year increase or the aggregate total of a state's directed payments make up a large percentage of a state's overall Medicaid managed care budget, those changes make it difficult for CMS to evaluate whether the Medicaid managed care capitation rates provide for all reasonable, appropriate, and attainable costs under the contract. We are therefore only able to provide an incomplete and limited opinion on whether those state directed payments are likely to result in total Medicaid managed care capitation rates that are actuarially sound, requiring us to conduct a more thorough inquiry than we would otherwise have to do. We have never knowingly approved an increase of state directed payments of that

size before. And in the past, we have had concerns when a state's requested state directed payments comprised a large proportion of the state's total Medicaid managed care spending. We consider 25% of its total Medicaid managed care spending to be a large proportion of Texas's Medicaid managed care spending. We were also concerned about the large year-over-year increase in the total amount of Texas's state directed payments. If those payments were actuarially sound last year, we were concerned that they might not be actuarially sound this year due to the large increase in their size without any corresponding expansion of Texas's Medicaid population or the services covered. We communicated to Texas during meetings on August 20, 2021 and August 24, 2021, that OACT was in the process of reviewing Texas's rates and had concerns about the aggregate amounts. During our meetings and in our written questions to Texas, we asked about the dollar amounts and impacts of its state directed payments, including questions about the specific amount of the increase, why that amount is reasonable, and Texas's rationale for an increase in state directed payments of that size. We updated our analysis about the reasonableness of the state directed payments each time we received additional information from Texas.

26. Texas has acknowledged that it "understands from its call with CMS on August 20, 2021 that the proposed CHIRP would be the largest [directed] payment" that CMS has ever approved and that the proposed payment itself is significantly larger than its predecessor, UHRIP. *See* Ex. A at 15.

27. The approach CMS took to determining whether Texas's requested state directed payments satisfy the actuarial soundness requirement is consistent with how CMS has reviewed other states' requested state directed payments. CMS does not in its normal course of reviewing a state's requested state directed payments conduct an actuarial analysis of those payments

individually or in the aggregate. *See* Ex. C, Letter from Anne Marie Costello, Acting Deputy Administrator and Director of the Center for Medicaid and CHIP Services, to State Medicaid Directors (Jan. 8, 2021).[1] In fact, CMS could not conduct an actuarial analysis of a state's requested state directed payments in isolation because an actuarial analysis can be conducted only on a state's rate certification submission and the overall capitation rates; it cannot be conducted based on contract terms alone. An actuarial analysis is used to determine whether a state's total Medicaid capitation rate is actuarially sound. That total capitation rate is calculated based on the state's complete managed care contract, including rates for all covered services and any additional payments under the state directed payments. Generally, CMS does not have access to a state's managed care contract until after it has completed its review of the requested state directed payments. Once CMS has granted prior approval of those payments as required by federal regulation, the state incorporates them into its managed care contracts and rate certifications. The managed care contracts and rate certifications are then submitted to CMS for

[1] That guidance provides as follows:

> All contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under 42 C.F.R. § 438.6(c)(1)(i) through (iii) must be developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices. Under the definition in 42 C.F.R. § 438.4, actuarially sound capitation rates are "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract."
>
> As part of ensuring that the final capitation rates paid to the plan are reasonable, appropriate, and attainable for the populations to be covered and the services to be furnished under the contract, as well as adequate to ensure access to care, CMS has required states to demonstrate that the state directed payments result in provider payment rates that are reasonable, appropriate, and attainable as part of the review of the preprint. To do this, CMS has required an analysis from states to understand the relative effect of the directed payment on reimbursement for each service type and each provider class receiving the state directed payment(s). Specifically, this analysis must provide the average base rate paid by plans to providers absent the impact of state directed payments, the effect each state directed payment(s) has on reimbursement for the service type(s), and any additional effects of permissible pass-through payments on reimbursement using a standardized measure (e.g., as a percent of Medicare or the Medicaid state plan rate). This analysis must be specific to each service type included in the state directed payment and specific to each provider class identified.

federal review and approval, which includes an analysis by OACT to ensure that the resulting capitation rates in the rate certifications are actuarially sound. Only then can CMS determine whether a state's managed care capitation rate is in fact actuarially sound. In reviewing a state's requested state directed payments, however, CMS's regulations require that we determine whether those payments were developed in a way that would result in actuarially sound capitation rates and be consistent with actuarial principles and practices. Texas is familiar with that process as it has gone through federal review of state directed payments and managed care capitation rates in previous state fiscal years. Based on its participation in that process, Texas is aware that CMS's review of state directed payments does not and could not include a final determination of actuarial soundness.

28. While we have discussed Texas's state directed payments as a group when discussing whether those payments would in the aggregate result in a Medicaid managed care capitation rate that is not actuarially sound, we have generally considered each of Texas's state directed payments individually. Texas has since made changes to its state directed payments as a result of our meetings and the written back-and-forth document through which Texas responded to our questions and provided us additional information about the reasons for the increase in the total amount of SDP payments. Those changes include Texas's agreement to limit CHIRP payments to 90% of the ACR. The information Texas provided included a revised reimbursement analysis indicating that the payments would not exceed the ACR.

29. The state has also provided explanations for the year-over-year increases in its CHIRP program. Texas submitted a revised preprint implementing the CHIRP payment cap on September 15. After reviewing the revised preprint and considering the additional information Texas submitted, our actuarial soundness concerns were resolved. Shortly after reaching that

conclusion, the federal review team communicated to Texas in a November 2 meeting that we have no more concerns or questions about the size of its CHIRP program. In our November 10, 2021 meeting we informed Texas that there were no remaining concerns about actuarial soundness or the size of the proposed SDPs for any of the five proposed SDPs.

Texas's Proposed Directed Payments Failed to Link Payments to Utilization

30. During the course of reviewing Texas's state directed payments, CMS determined that four of Texas's state directed payments were designed in a way that could result in payments to providers that were not based only on utilization of services during that state fiscal year. CMS identified this issue with the QIPP, TIPPS, BHS, and RAPPS payments.

31. CMS's policy requires that any "state directed payments need to be conditioned on the delivery and utilization of services covered under the contract for the applicable rating period. Therefore, state directed payments must be tied to utilization and delivery of services covered under the contract during the corresponding contract rating period; payment cannot be based solely on historical utilization." Ex. C at 4. To satisfy this requirement, states must ensure that total payments to providers are based only on the utilization of services during that year.

32. For the four state directed payments listed above, Texas would instruct its managed care plans to pay providers interim payments throughout the state fiscal year based on that provider's historical utilization data from previous state fiscal years. After the fiscal year ended, the plans would conduct a reconciliation process in which it would balance payments made throughout the state fiscal year from Medicaid managed care plans to providers for services provided to Medicaid beneficiaries with claims and quality data that the providers must submit to the plans. After the state fiscal year ends, the plans would use the claims and quality data submitted by the providers to determine the total amount of Medicaid payments that the

provider should have received based on that year's utilization. If the provider received more Medicaid payments than it should have, the plan would be required to recoup those funds; if the provider received less payments than it should have, the plan must pay the provider any underpayment amount. However, Texas's proposed state directed payments would apply an 18% reconciliation threshold for QIPP and TIPPS and 10% reconciliation threshold for BHS and RAPPS, meaning providers and Medicaid managed care plans would be required to reconcile their payments only if the amount of under- or overpayment exceeded that threshold.

33. During CMS's review of Texas's state directed payments, CMS identified two potential problems with Texas's reconciliation process. First, under Texas's process, interim payments made under QIPP, TIPPS, BHS, and RAPPS could potentially require substantial adjustments through the reconciliation process if actual utilization in a given year is significantly different than historical Medicaid managed care utilization data. Such a difference could result in a substantial increase or decrease in the total amount of Medicaid managed care costs in Texas and result in a different total capitation rate for Texas's Medicaid managed care program. Such a change would potentially require Texas to adjust its managed care capitation rate from the one it submitted to and received approval of from CMS. In 2020, CMS approved Texas's QIPP directed payment request that made payments to providers based on historical utilization data and reconciled those payments after the plan year ended. *See* Ex. D, Letter from Bill Brooks, Director of the Division of Managed Care Plan Operations, Centers for Medicare & Medicaid Services, to Stephanie Stephens, Associate Commissioner, Texas Health and Human Services Commission (Aug. 3, 2020). In that approval, we instructed Texas that "if the state continues to pay this component as a uniform increase, CMS expects the state to move away from a reconciliation requirement and instead require plans to pay based on the actual facility bed days

during the contract rating period." *Id.* at 2. Texas's request indicated it would continue to pay QIPP using a uniform increase and would continue its reconciliation requirement. Texas also expanded the use of the reconciliation requirement in the three new state directed payments, TIPPS, BHS, and RAPPS, even though Texas knew about CMS's historical concerns with the practice in QIPP. Accordingly, CMS raised concerns with that process in several rounds of questions with Texas to determine whether it could approve such a payment notwithstanding the state's failure to make payments based on actual utilization. In its responses to our questions about Texas's reconciliation approach, Texas explained that it "may consider a change to payments based upon claims at the time of adjudication in the future." Ex. A at 8 (Round 5 feedback document). In the interest of working collaboratively with Texas, we considered Texas's agreement to consider changes to make payments based on actual utilization in the future sufficient to resolve that reconciliation issue. *See* Ex. E, letter from John Giles, Director of the Division of Managed Care Policy, Centers for Medicare & Medicaid Services, to Stephanie Stephens Associate Commissioner, Texas Health and Human Services Commission (Nov. 15, 2021) ("QIPP Approval Letter"); Ex. F, letter dated November 15, 2021, from John Giles, Director of the Division of Managed Care Policy, Centers for Medicare & Medicaid Services, to Stephanie Stephens Associate Commissioner, Texas Health and Human Services Commission (Nov. 15, 2021) ("BHS Approval Letter").

34. Second, we identified that Texas's use of a reconciliation threshold in those payments would likely result in payments to providers that was not tied to the utilization and delivery of services during the applicable plan year in violation of CMS's policy. Texas agreed to set a 0% reconciliation threshold for those payments, which resolved our concern with reconciliation with respect to those payments. *See* Ex. E; Ex. F.

Quality Improvement Issue

35. In reviewing the QIPP, TIPPS, and BHS payments, we were concerned that Texas's payments would be based on performance linked to non-Medicaid managed care enrollees and that those payments may not ensure providers are achieving improvement over the previous year.

36. With QIPP, we noted that an HHS Office of the Inspector General (OIG) audit had found that in previous years, nursing facilities had received QIPP payments despite a decline in performance. One component of Texas's proposed QIPP payment would provide quarterly quality improvement incentive payments if that provider showed either a 5% improvement in its performance metrics *or* if that provider performed at least 5% above the national average. Under Texas's current QIPP submission, we were concerned that nursing facilities could receive increased payment based on performance despite a significant *decline* in that facility's performance by basing the payments on a national average only. Other components of Texas's QIPP proposal were based on the provider meeting certain benchmarks, which could also result in incentive payments to providers despite a decline in the provider's quality. We advised Texas of specific modifications the state could make to resolve this quality issue, including by adding a threshold requirement for a provider to at least maintain or improve its performance, or for payments tied to a benchmark, for Texas to adopt a requirement "that if the provider already was achieving the benchmark at the start of the performance period, they would have to demonstrate improvement or maintenance in period over period performance (e.g., year over year or quarter over quarter.)" Ex. A at 11. Texas submitted a revised preprint for QIPP, on October 13, 2021, which included language establishing a requirement in which a provider would not receive quality-based payments if the provider performs worse than its initial baseline by more than a set

amount. *Id.* at 12. CMS indicated to Texas on October 18, 2021, that it had received the revised preprint and was reviewing those changes. CMS indicated to Texas on November 2 that it considers this issue to be resolved based on Texas's changes.

37. With QIPP, TIPPS, and BHS, Texas's proposed state directed payment characterized at least one component of that payment as "Quality Payment/Pay for Performance." When Medicaid managed care payments are made based on quality rather than utilization of services, those performance payments must be measured only with respect to Medicaid managed care enrollees and they must be tied to quality measures (rather than a uniform payment increase). However, the purported "Quality Payment/Pay for Performance" component of Texas's TIPPS and BHS submissions appeared to provide only for payments based on utilization, and we were unable to determine whether any quality-based payments would be limited to data related to Medicaid managed care enrollees (as opposed to a provider's other patients). Texas initially responded that it had developed a "hybrid model" in which providers must meet quality requirements, but "payment is still triggered by Medicaid managed care utilization." Ex. A at 59. Texas notified CMS on September 10 that it would amend its TIPPS and BHS preprints to more accurately characterize those components as a "uniform rate enhancement" and that the state would "require provider-reported measures to be stratified by Medicaid managed care only for the purposes of the evaluation." Ex. A at 35. We informed Texas that its proposed amendments would resolve the issue on September 16, 2021, and Texas provided written confirmation of those amendments on September 29, 2021.

Evaluation Plan Issue

38. Our initial review of QIPP indicated that Texas must refine its evaluation plan to sufficiently evaluate the effectiveness of QIPP payments independent of the impact from other

programmatic changes or state directed payments. We advised Texas that it could resolve that issue by using a particular data set that is readily available to Texas, the Medicare Minimum Data Set 3.0 data collected by Texas Medicaid, in its evaluation of the QIPP payment, which would provide standardized raw assessment data. We also advised Texas to include some qualitative analysis in its evaluation. Texas agreed to explore that approach and to obtain cost estimates and an estimate of how long it would take to begin using raw data in its evaluation. Based in part on that agreement, we determined that Texas's evaluation plan for QIPP was sufficient on or around November 4, 2021, after confirming information between CMS and Texas during a meeting on that same day.

39. Our initial review of Texas's RAPPS, CHIRP, TIPPS, and BHS state directed payments indicated the state's evaluation design would be insufficient because Texas's stated evaluation plan would not ensure that the effect of each state directed payment can be appropriately evaluated and that Texas had failed to provide for consistent baseline data to demonstrate year-over-year changes. Specifically, we noted that those directed payments would use state-level data rather than provider-reported measures in the evaluations. We also noted that there was significant overlap in the services being provided by RAPPS, CHIRP, TIPPS, and BHS because those payments target similar services and largely share the same goals. And we noted that Texas had not identified any overall quality improvement targets for those state directed payments. We were therefore concerned that Texas could not clearly evaluate the efficacy of each state directed payment at improving the economy and efficiency of health services provided to Medicaid beneficiaries through state-level data alone. *See* 42 C.F.R. § 438.6(c)(2)(ii)(D). We also explained that state-level data would be insufficient to measure the progress of state directed payments with smaller provider categories, such as rural health clinics.

We provided Texas with several specific modifications the state could make to its evaluation plan. The state could provide one annual evaluation for RAPPS, CHIRP, TIPPS, and BHS that includes measures attributed specifically to each state directed payment. The state agreed to use provider-reported measures in the evaluation and to provide one evaluation report. Texas also explained that it would include quality improvement targets for those state directed payments in its state fiscal year 2023 state directed payment requests that would be based on initial baseline calendar year 2021 provider-submitted data and historical state-level data. Texas also agreed to submit addendums to update each state directed payment's goals, if needed, to incorporate the complete set of calendar year 2021 data once it has received it in April 2022 and to incorporate state-level data from calendar year 2021 once it receives it in October 2022. Texas provided that explanation on October 22, 2021, and after considering it, we determined that the evaluation plan issue had been resolved.

Non-Federal Share Issue

40. The only remaining issue that Texas has not resolved concerns the requirement that federal Medicaid funds are available only where the state's share of the Medicaid payment comes from a permissible source. That issue applies to Texas's CHIRP, TIPPS, and RAPPS directed payments. CMS has a statutory obligation to ensure that the financing used as the non-federal share of Medicaid payments is permissible, so if we have reason to believe that the non-federal share of state directed payments is based on an impermissible financing scheme, we would be potentially violating our statutory obligations by approving those state directed payments without either verifying that the financing of the non-federal share is permissible, requiring the state to use a permissible financing scheme, or denying the requested state directed payments. In the past, we have approved smaller state directed payments where we have

identified a potential impermissible source of the non-federal share. In those cases, we had less information available to determine whether there was in fact an impermissible financing scheme in place and we approved the state directed payments while reserving our authority to defer or disallow Medicaid funds if we were to determine that there was an impermissible source of the non-federal share after additional factfinding. In this case, the three state directed payments that we believe likely use an impermissible source of the non-federal share are substantially larger than the amount of state directed payments Texas had requested in previous years and comprised nearly 25% of Texas's Medicaid managed care funds. And based on publicly available information and our discussions with Texas, we believe it is likely that the non-federal share of those state directed payments are funded using health care-related taxes and that there is a hold-harmless agreement in place. Accordingly, given the size of the state directed payments and the likelihood that an impermissible financing scheme exists, we believe it would be improper to approve CHIRP, TIPPS, and RAPPS without first resolving the financing issue.

41. A hold-harmless agreement likely exists because providers that pay the health care-related taxes used to fund those state directed payments are guaranteed to be reimbursed for those tax payments through arrangements known as Local Provider Participation Funds (LPPFs). We have found third-party documents that describe how LPPFs function in Texas. *See* Ex. G. Under those agreements,

- LPPFs collect revenue through hospital taxes imposed by numerous localities in Texas and transfer this revenue to the state Medicaid agency through intergovernmental transfers (IGTs).
- The state uses this revenue as a source of non-federal share of certain Medicaid payments, including proposed payments to taxpaying hospitals under three

pending state directed payment arrangements. "Hospitals that have little or no Medicaid volume" or those that do not qualify for relevant Medicaid payments are considered "net loss hospitals" because they "will pay more into the LPPF [through the hospital tax] than they receive in benefit in the form of an increased Medicaid payment."

- "…within 30 days" of paying its hospital tax, each net loss hospital receives a redistribution payment from hospitals that benefit from increased Medicaid payments in an amount "generally equal to 105 percent of the amount" of the total tax cost of the net loss hospital.
- The third-party materials also state, "The LPPF only works if everyone that is subject to the fee [the hospital tax] ends up with a benefit."

42. Such hold harmless agreements are impermissible under section 1903(w)(4) of the Social Security Act and CMS's regulations at 42 C.F.R. § 433.68(f)(3). Regardless of the source of the hold harmless arrangement, section 1903(w) prohibits federal Medicaid funds to be paid where the state's share of those Medicaid funds is financed using an impermissible non-federal share source, including those sources that might be derived from private entities through taxes and donations. Our regulation provides that "[a] taxpayer will be held harmless under a tax program if" the state "provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount." 42 C.F.R. § 433.68(f)(3). In the preamble the final rule establishing that provision, we explained that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any

part of the tax (through direct or indirect payments). A direct guarantee does not need to be an explicit promise or assurance of payment. Instead, the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy." 73 Fed. Reg. 9685, 9694 (Feb. 22, 2008). We further explained that "[w]e chose to use the term reasonable expectation because we recognized that state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless." If the providers paying healthcare-related taxes reasonably expect that they will be held harmless for any part of those taxes, a hold harmless arrangement exists.

43. CMS started to become aware of this issue in 2018 and 2019, when we conducted a two-county, cursory review of the state's LPPF funding source. CMS issued a letter in December 2018 to the state indicating the LPPFs for Dallas and Tarrant counties appeared to meet federal requirements based on a preliminary CMS review, but specified, "To the extent CMS discovers at a later date that these financing arrangements do, in fact, violate federal statute and regulation, CMS may take action to enforce compliance." CMS later discovered through independent research (consultant presentations publicly available on the web describing the LPPF hold harmless arrangement) the existence of redistribution of Medicaid payments among taxpaying providers to ensure they are held harmless for the cost of the tax. Since the initial communication with Texas, CMS has continued to attempt to obtain more information from the state and through other sources about the LPPF arrangements. Despite numerous requests, the state has not provided the information needed to determine whether the LPPF arrangements used to fund some of Texas's requested state directed payments meet federal requirements. With only very limited information from the state on the LPPF arrangements, CMS has relied on publicly available third-party materials for more complete information about the arrangements. CMS has

previously shared with the state this third-party description of the arrangement. Ex. G, David Salsberry, Presentation, The Present and Future of Medicaid (Aug. 17, 2017). Texas has not denied that the information provided in those materials is an accurate description of how the LPPFs operate in Texas or provided any information to CMS that refutes the third-party description as representative of the LPPF arrangements in the state. Texas's responses to our repeated requests for additional information or evidence that such arrangements are not in place in Texas further suggest they do exist. For example, on our November 2, 2021 call, Texas officials insisted that it could not restrict how providers use their Medicaid payments after the providers have received those payments. Ex. B at 96.

44. We have tried repeatedly to work with Texas to resolve this issue by asking Texas either to provide us with information necessary to demonstrate that such arrangements are not in place or to exercise its oversight authority over providers in Texas to ensure the arrangements have ended. To date, Texas has not taken either of those actions and instead has indicated that it does not believe the state's LPPFs violate the Medicaid statute. Texas has stated that it intends to provide limited oversight related to non-federal share financing. *See* Ex. H, Texas HHSC, Attachment B—Oversight and Monitoring Plan for Local Funds Used in Medicaid in Texas. However, the state's LPPF-related oversight would only cover activities directly involving units of government. It has also offered attestations/certifications regarding agreements, but again, only as they relate to units of government. Specifically, Texas made clear on September 29, 2021 and October 22, 2021 that it does not intend to oversee or review transactions among private entities and has challenged CMS's ability to do so. *See* Ex. A at 76–77. Texas's actions are insufficient because the state is only agreeing to oversee a portion of the health care-related

tax program and ignoring taxpayer actions that could include redirecting Medicaid payments to other taxpayers that results in all taxpayers being held harmless for any health care-related tax.

45. One option for resolving this issue that CMS has presented to Texas is for the state to provide attestations from the state that hold harmless agreements are not in place within the state. In response, Texas has provided only limited, insufficient assurances that cover only units of government and address whether units of government compel provider participation in agreements to redistribute payments, not whether the payment redistribution is occurring. That attestation is inconsistent with what we have requested and does not address our concerns with the LPPF arrangements in Texas. We are not requiring Texas to provide attestations, but are offering attestations as an expedient way to resolve the non-federal share issue. This option is intended to be convenient for Texas and is an alternative to the more resource-intensive investigations that might otherwise be necessary to determine exactly how the LPPF arrangements work in each locality. Such an investigation would require desk reviews and/or onsite reviews of participating providers. As part of those investigations, the providers would be expected to provide documentation or information regarding the arrangements and might include statistical records, be subject to observations, provide interviews, respond to written inquiries, provide copies of correspondence, provide copies of written policies and procedures and other substantiating documentation. Needless to say, such a process would be a substantial burden on CMS, Texas, and the providers.

EXHIBITS

46. Attached hereto as Exhibit A is a true and correct copy of CMS's Round 5 Feedback to Texas and Texas's Responses, which Texas sent to CMS on November 15, 2021.

47. Attached hereto as Exhibit B is a true and correct copy of CMS's Notes from its Meetings with Texas from August 18, 2021, through November 15, 2021.

48. Attached hereto as Exhibit C is a true and correct copy of a letter dated January 8, 2021, from Anne Marie Costello, Acting Deputy Administrator and Director of the Center for Medicaid and CHIP Services, to State Medicaid Directors.

49. Attached hereto as Exhibit D is a true and correct copy of a letter dated August 3, 2020 from Bill Brooks, Director of the Division of Managed Care Plan Operations, Centers for Medicare & Medicaid Services, to Stephanie Stephens, Associate Commissioner, Texas Health and Human Services Commission.

50. Attached hereto as Exhibit E is a true and correct copy of a letter dated November 15, 2021, from John Giles, Director of the Division of Managed Care Policy, Centers for Medicare & Medicaid Services, to Stephanie Stephens Associate Commissioner, Texas Health and Human Services Commission, approving Texas's Quality Improvement Payment Program state directed payment.

51. Attached hereto as Exhibit F is a true and correct copy of a letter dated November 15, 2021, from John Giles, Director of the Division of Managed Care Policy, Centers for Medicare & Medicaid Services, to Stephanie Stephens Associate Commissioner, Texas Health and Human Services Commission, approving Texas's Behavioral Health Services state directed payment.

52. Attached hereto as Exhibit G is a true and correct copy of a presentation by David Salsberry dated August 17, 2017 and titled "The Present and Future of Medicaid."

53. Attached hereto as Exhibit H is a true and correct copy of a document submitted by Texas to CMS titled "Attachment B—Oversight and Monitoring Plan for Local Funds Used in Medicaid in Texas."

Pursuant to 28 U.S.C. § 1746, and under penalty of perjury, I declare the foregoing is true and correct to the best of my knowledge.

11/16/2021
Date

John Giles
JOHN GILES

Texas & CMS Meeting: Friday, August 20, 2021

Discussion: State Directed Payment Preprint Modifications

CMS is committed to working with Texas to support safety net providers and to ensure that safety net financing and reimbursement approaches advance measurement and accountability for improving health equity and quality. We reiterate our offer, outlined in CMS' August 13, 2021 letter, to address the near-term stability for safety net providers while CMS and Texas continue to work toward a more sustainable, equitable, and high quality safety net, by approving an amendment to the state's demonstration, if timely submitted, that would extend the DSRIP program for one year (through September 30, 2022).

At the state's request, CMS is providing, in the chart below, more detailed information under Option 2, which was outlined in the Appendix to the August 13, 2021 letter. As described below, the state could modify all five (5) state directed payment preprints currently under CMS review for SFY 2022 to be consistent with statutory and regulatory requirements. Such modifications will need to satisfy all the terms below, with sufficient data to CMS as described. Most importantly, the state will need to ensure that the overall aggregate amount of payments is significantly less than previously proposed to satisfy actuarial concerns.

CMS will review the information submitted by the state, which may lead to additional communications back and forth between the state and CMS.

As an alternative, the state could resubmit the preprints as described in option 1, and CMS could timely approve those preprints before September 1, 2021.

In either case, CMS is willing to work with the state on the extension of DSRIP, subject to the state's submission of an amendment, consistent with the STCs in the THTQP demonstration by Monday, August 23.

CMS will work with the state over the course of the next year on a more sustainable approach to a high-quality, equitable heath safety net.

September 10, 2021 Update: CMS responses are provided below, highlighted in yellow.

September 24, 2021 Update: CMS responses are provided below, highlighted in green.

October 18, 2021 Update: CMS responses are provided below, highlighted in pink.

November 10, 2021 Update: CMS responses are provided below, highlighted in blue.

Overarching comments from the CMCS Division of Quality and Health Outcomes:

RAPPS, CHIRP, TIPPS, and BHS:

1. **Using state-level data in the evaluations**.

- Upon review, it appears that many of the measures the state will be using to evaluate the SDPs will be at the state-level, even after the EQRO develops an attribution methodology. Given the overlap in services being provided by the SDPs, we have concerns about whether Texas can clearly evaluate the economy and efficiency of their progress in elevating the health services provided to Medicaid beneficiaries through the SDPs.
- We see this currently evolving evaluation methodology as unable to capture the progress of SDPs with smaller provider categories such as rural health clinics. For example, how will the state determine that improvement is driven by a rural health clinic on the ED visit measure by analyzing at the state-level?
  State Response: An evaluation could never wholly attribute, for example, an increase in access to services in a health clinic to a reduction in ED utilization, because there are more factors at play – it requires the whole system to reduce ED utilization – ambulance, payor, Medicaid member, clinics, etc. Additionally, the Potentially Preventable ED Visit (PPV) measure can never be directly attributed to a non-hospital provider. Potentially Preventable Events (PPEs) are structured as a ratio of predicted events at the hospital divided by observed events at the hospital, so any improvements made outside of the hospital setting can only be correlated with any reduction in observed events at the hospital. Another complicating factor is that Medicaid members have freedom of choice in provider. And multiple provider types participating in these SDPs would be contributing to the outcomes for Medicaid beneficiaries as a system.

  The state will amend the evaluation to add more provider-reported measures to isolate the performance of the participating providers in the respective DPPs. The state is open to any suggestions and strategies CMS may have to include in the evaluation. HHSC will consider amending proposed measures in UHRIP and RAPPS to ensure more provider-reported outcome measures can be used for the evaluation. This will delay the first provider reporting period.
  As the SDPs are advancing the state's quality strategy on the whole, HHSC will also include statewide measures in the combined evaluation of DPP BHS, CHIRP, RAPPS, and TIPPS (see response to comment 2 below).

2. **Providing one evaluation for SDPs.**

- Currently, the state is unable to isolate the effects of these SDPs due to the SDPs reinforcing one another. Though these SDPs target different providers, they target similar services and largely have the same goals. The state appears to consider them a unit of policies working together to improve quality in the state, and not as separate tools to be measured individually. However, we need to better understand how the state's efforts to improve healthcare delivery to Medicaid beneficiaries is affecting their health and well-being and without full attribution, we do not see how an evaluation report could discern this. One option discussed with the state is to provide one annual SDP evaluation for the four SDPs which will include measures attributed specifically to each SDP.
  State Response: The state will provide one evaluation report to minimize administrative burden, and based on the reasons explained above, the state will primarily use provider-reported measures in the evaluation.

ALL SDPs:

3. **Recommendation to add clarity to the findings of all Texas SDPs.**

- To relieve the struggle of controlling for factors external to the Texas SDPs, CMS recommends conducting outreach with participating providers (e.g., surveys or key informant interviews) to understand their experience with each SDP. Qualitative analysis can be critical to contextualizing and validating quantitative findings.

  State Response: The state has already proposed incorporating qualitative data via the structure measures questions that will be answered by providers.

State Directed Payment Topic	Modifications/Information Required for State Fiscal Year (SFY) 2022 Under Option #2
Quality Incentive Payment Program (QIPP)	1. Remove the 18% reconciliation threshold on component 1 and base payments only on current utilization or performance measured during the contract rating period (rather than historical utilization or performance). **State Response:** Texas has utilized this type of program structure since the inception of QIPP in 2017. CMS noted in the SFY 2021 program approval: "if the state continues to pay this component as a uniform increase, CMS expects the state to move away from a reconciliation requirement and instead require plans to pay based on the actual facility bed days during the contract rating period." Texas understood this guidance to indicate that efforts should be made to show progress prior to the SFY 2022 submission but did not understand CMS to be stating that the state must definitively eliminate this structure prior to SFY 2022. As CMS is aware, nursing facility providers have undergone tremendous strain since the beginning of the public health emergency as they have worked to respond to COVID-19. For that reason, Texas did not undertake major structural changes to QIPP for SFY 2022, except for continuing advancements in our quality goals. To that end, the state has enhanced Component 1 to require a PIP with documented progress on the PIP, which we believe is a considerable advance towards a more performance-based payment. With respect to the existing reconciliation threshold, our preliminary review of QIPP Year 4 data suggests a likelihood of a reconciliation required following the program period. The state considers claims to be adjudicated 180 days following the date of encounter and these numbers are subject to change, but the state would like to emphasize that the potential impact of COVID-19 on utilization is not yet known, and the state believes the threshold is appropriate for QIPP Year 5. However, Texas also believes that the necessity of the continuation of this program for SFY 2022 is critical to the quality of services delivered to the Medicaid nursing facility beneficiaries. We understand from the call between Texas and CMS on August 20, 2021, CMS will not consider Texas's proposal of a reduced threshold for SFY 2022, with a complete elimination of the structure for SFY2023. In an effort to achieve a pathway forward for this important and long-standing program, Texas would like to utilize a payment structure where interim payments for SFY 2022 are based initially upon the historical utilization data, with final payments made based upon actual data at the end of the program year, with no contingency for a variation in utilization data. This approach will allow for consistent

payments to be made through the program year, but final payments to be based exclusively on actual utilization. Would CMS agree that this approach resolves any outstanding concerns about the tie to utilization? If so, Texas will submit a revised pre-print to this effect immediately.

CMS Response: What the state has described for SFY 2022 for QIPP Component 1, where interim payments would initially be based upon historical information but reconciled to actual utilization during the rating period, would be permissible under the regulation. We do have a few follow-up questions to ensure our understanding of this arrangement:
State Response: Thank you for this feedback; we are glad that this matter can be considered resolved for the purposes of consideration of our pending SDP approvals.

a. Please describe in more detail how the payments will be made under the state's new proposal to replace the reconciliation threshold. Please provide a step-by step breakdown for how payment will work for both the MCOs and providers -- including whether the interim payments will be based on the same monthly payment amount currently proposed in the preprint, when interim payments will be made based on historical utilization, how long such interim payments will continue to be made based on historical utilization, when the payments will be made based on actual utilization, and how the initial payments made based on historical utilization will be reconciled to actual utilization during the rating period. Please also discuss if the reconciliation could potentially result in recoupments from MCOs or providers.
State Response: Please see Attachment A for a timeline and high-level description of the process. There will be three subprocesses required as part of this overall process. In the first subprocess, HHSC will pay MCOs a monthly actuarially sound capitated rate based upon actual caseloads each month. MCOs will adjudicate actual claims through normal processes and then submit to HHSC encounter data. Typically, due to claims processing timelines, encounter data for a rating period is usually considered substantially complete approximately 120 days after the end of the rating period, which for Texas means December 31, 2022 for the September 1, 2021 through August 31, 2022 rating period. In a separate subprocess, HHSC receives quality-related data from providers that is required as a condition of participation in the program. HHSC will direct MCOs to issue payments to providers based upon historical data and using funds received by the MCO in the monthly capitated rate that was paid. The MCO will issue the interim payment to the provider monthly. In the final subprocess, approximately 120 days after the end of the rating period, HHSC will reconcile the historical utilization that was used as the basis of the interim payments to the actual encounters reported by the MCOs. HHSC will then direct the MCOs to recoup from and redistribute funds to providers based upon the reconciled information. The MCOs will not experience recoupments as the capitated rates paid to the MCOs will include all necessary payments. Providers may experience recoupments or receive additional funds based upon historical-to-actual utilization fluctuations.

CMS Response (9/24/2021): CMS appreciates the additional information provided on the process. CMS would like to confirm the following:

	State Response (9/29/2021): HHSC is happy to share additional information to confirm CMS' understanding of the reconciliation process. Per CMS' September 10, 2021 statement that the reconciliation process would be permissible under the regulation, we are glad that this matter can be considered resolved for the purposes of consideration of our pending SDP approvals. 1. The 3 processes indicate that no changes will be made to the payments the MCO receives from the state; changes to the payments would occur for the providers within what the state has paid the plans, is that correct? State Response (9/29/2021): Yes, that is the intent. However, there may be modifications to MCO payments if the redistributions are significant to a point that the resulting adjustments would no longer be considered actuarially sound. 2. Does the state anticipate any amendments to the rates or rate certifications to account for the reconciliation requirement? **State Response (9/29/2021)**: Not at this time. 3. How will the state inform the plans of any needed recoupments or redistributions of the funds to providers? Through updates to the contract? **State Response (9/29/2021)**: The state will inform the MCOs via an updated payment scorecard that will show any provider level payment adjustments (positive or negative) that are required. **CMS Response (10/18/2021):** We understand that the payment scorecard has historically been used for payments to QIPP providers, and that the state will now include direction in the MCO contracts for using this scorecard for when recoupments or redistributions are needed for providers participating in TIPPS, BHS, and RAPPS. Is this correct? **State Response (10/22/2021)**: The state will create a scorecard specific to each program that is similar to the scorecard used in QIPP, but there will not be a consolidated scorecard for all programs. The program-specific scorecards will be used to indicate when recoupments or redistributions are necessary. 4. CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A. **State Response (9/29/2021)**: The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk. 5. The response to Question 9a in the preprint indicates that the payment for Component 1 will be a uniform increase of 36.9% per claim. Can the state confirm this is correct? Are the payments made under Component 1 to providers on a PMPM basis or on a per service (or per claim) basis? Would the percentage amount change with the reconciliation?

State Response (9/29/2021): Yes, the percentage increase is approximately 36.9%. To be clear, however, the impact of the payment increase is the percentage identified on a per claim basis; however, the state intends on making the payments as a lump sum monthly payment during the program year, prior to the reconciliation to actual NF claims at the end of the program period. The percentage could change as the state intends to maintain the size of component 1 as identified in the pre-print but would adjust the percentage per claim if the actual utilization varies from the historical. The adjustment would take place at the time of the reconciliation.

CMS Response (10/18/2021): Our understanding from previous rounds of review is that the targeted amount for Component 1 is $448,305,000; however, our understanding is that this amount excludes provisions for administration, risk margin, and premium tax. Can the state please clarify the targeted amount of Component 1 funding that they intend to reconcile to? Will this targeted amount include any provisions for administration, risk margin, and premium tax?

State Response (10/22/2021): The amount identified for Component 1 is an estimate based upon the proposed program size. However, if the actual program size fluctuates as a result of caseload, the size of Component 1 would fluctuate proportionately as Component 1 is designed to be equal to a percentage of the overall program value. The reconciliation performed at the end of the program year will be performed to reconcile to the actual value of Component 1 based upon the actual value of the overall program as paid through the program year. All managed care capitated payments will include administration, risk margin, and premium tax, as appropriate. Component 1 value listed above does not include any provisions associated with administration, risk margin, and premium tax.

6. The state indicated on calls that the state intended to continue incorporating this payment arrangement as an adjustment to base rates rather than a separate payment term. Given the revised reconciliation process for Component 1, can the state affirm that it still plans to incorporate all components of this payment arrangement through an adjustment to base rates or would the state pay any part of this payment arrangement, such as Component 1, as a separate payment term?

State Response (9/29/2021): Yes, all components will be through an adjustment to base rates.

CMS Response (10/18/2021): The state indicates in the response to question 5 above that the uniform percentage increase currently documented in the preprint would change at the time of the reconciliation as the state intends to maintain the size of Component 1 funding currently identified in the preprint. Is the state's goal under Component 1 or any other Component to ensure that exactly a certain amount (e.g., $448,305,000) is expended by the plans for payments to providers under any specific components (e.g., Component 1)? Or are the amounts listed for each component an estimate that is subject to change? If so, what would cause it to change?

State Response (10/22/2021): To clarify, the state intends to maintain the size of Component 1 as a percentage of the overall program value; however, the gross value of Component 1 may change if the overall program value fluctuates from the estimated value. This fluctuation would be a result of changes in caseload from the forecasted caseload for the fiscal year. However, the payments will still be reconciled against actual utilization, so the actual percentage of program value compared to actual utilization may

result in a different percentage rate increase than the estimated rate increase, which is based upon historical utilization and estimated program values.

CMS Response (10/18/2021): Does the state direct the plans to set aside any portion of the capitation rate paid to them for this payment arrangement?
State Response (10/22/2021): No. The portion of the capitation rate attributed to each DPP has been separately identified and reported to the MCOs but no direction has been provided on how the MCOs should "set aside" these funds.
CMS Response (10/18/2021): Are the plans directed to use a specific portion of the capitation rates paid to them to pay out Component 1?
State Response (10/22/2021): No. The capitation rates have been calculated separately for each DPP; however, this add-on rate isn't delineated between the various components.

7. Please also revise the preprint to include the information on the reconciliation process described in Attachment A.
State Response (9/29/2021): Please see the changes in the attached pre-prints, per your request.

b. Can the state confirm that all payments (including the interim payments based on historical data) will be reconciled to actual utilization data during the rating period? Or will those initial interim payments remain based only on historical utilization?
State Response: All payments will be reconciled to actual utilization data during the final reconciliation.

CMS Response (9/24/2021): See CMS Round 3 responses, Question 4 above - CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.
State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

c. We will note that states that make interim payments based on historical utilization and then reconcile to actual data have noted that reconciliations like this can be administratively burdensome.
State Response: Noted. The importance of the program to our healthcare safety net is significant so HHSC will absorb the administrative burden.

CMS Response (9/24/2021): See CMS Round 3 responses, Question 4 above - CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.

State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

d. CMS' understanding from previous responses is that the reconciliation threshold is a part of the state's administrative code. Can the state confirm that this change can be implemented without changes to the administrative code? If not, can the state describe the process and timing for making such changes? If changes to the administrative code are needed, will the state be able to implement those retroactively back to the start of the rating period?

State Response: Implementing this change will require the state to modify the Texas Administrative Code. HHSC will propose that rule changes will apply to the entire program period, though the effective date of the rule change will be subsequent to the start of the rating period.

CMS Response (9/24/2021): Can the state elaborate on the timeframes that would be needed to complete the state rulemaking process? Can the state also comment on if they anticipate challenges to the rulemaking and what impact those would have on implementation timelines?

State Response (9/29/2021): The Texas rulemaking process requires filing of a proposed rule with the Texas Register by Monday at noon to have the proposal published 11 days later (the second Friday after submission). Proposed rules are generally posted for a 30-day public comment period. Following the public comment period, the rule can be adopted with or without changes. Typically, a rule takes effect 20 days after the date the rule is filed with the Texas Register. This total process requires a minimum of 51 days; however, accounting for time necessary to prepare the rules for publication, to review public comments, and make any changes as a result thereof, HHSC typically assumes a minimum of 90 days will be necessary. HHSC anticipates receiving public comments but also anticipates that providers prefer changes be made if they are necessary for CMS approval for state fiscal year 2022.

For more information, CMS may wish to visit our webpage on rulemaking: https://www.hhs.texas.gov/laws-regulations/policies-rules/health-human-services-rulemaking.

CMS Response (10/18/2021): From the description above, it sounds like CMS would not expect rate amendments or contract amendments to implement the proposed changes until 90 days after the start of rulemaking at the state level. Is this correct?

State Response (10/22/2021): With respect to rule making changes described above, the state does not anticipate that rate changes or contract amendments would be required to implement the changes proposed for QIPP, so the rates and contracts already filed with CMS will stand.

e. Can the state please describe how this new approach will be accounted for in the capitation rates? Will the directed payment continue to be incorporated into the rates as an adjustment to the base data or will the directed payment now be incorporated into the rates as a separate payment term? It would be helpful for the state to clarify how this new approach would impact the amounts included in the initial certification, and if the state and actuary intend to amend the rates in the future once the final payments based on actual utilization are known.

State Response: We expect that the QIPP would continue to be incorporated as an adjustment to the base capitation rates and included in the monthly premium. Once final data is available at the end of the year, a retroactive adjustment to the QIPP capitation rates may be necessary, in which case HHSC would amend the MCO contracts and submit an actuarial rate amendment.

CMS Response (9/24/2021): See CMS Round 3 responses, Questions 1, 2 and 6. Appendix A, process 3 does not indicate that there will be any changes to the MCO payments and the state's response above states, "The MCOs will not experience recoupments as the capitated rates paid to the MCOs will include all necessary payments." However, this response indicates that retroactive adjustments to the capitation rates may be necessary. Can the state please clarify if the state expects or anticipates an amendment to the rates and if amendments to the rate certifications may be needed? Please also identify under what circumstances amendments would be needed?

State Response (9/29/2021): The state does not anticipate making any prospective capitated rate changes based upon this modification. However, once final data is available at the end of the year, a retroactive adjustment to the capitation rates may be necessary if the degree of recoupments and redistributions is significant to the point that the capitated rates are no longer actuarially sound. If that occurs, HHSC would amend the MCO contracts and submit an actuarial rate amendment.

CMS Response (10/18/2021): The state indicates that there may be modifications to MCO payments if the redistributions are significant to a point that the resulting adjustments would no longer be considered actuarially sound. We would appreciate better understanding under what circumstances the MCO rates would be revised.

1. Can the state and its actuary please discuss how you are defining "significant" in this instance, and what threshold would trigger adjustments to the MCO capitation rates. Please address both the potential instances when MCOs are required to pay out more QIPP payments than the amount of funding included prospectively in capitation rates, and when MCOs are required to pay out less QIPP payments than the amount of funding included prospectively in the capitation rates.

State Response (10/22/2021): The intent of any reconciliation would be to ensure that all MCO capitation rates continued to be considered actuarially sound and to ensure that no MCO was inadvertently harmed (or profited) due to shifts in utilization and provider payments that are beyond their control. The threshold for triggering a retroactive rate change is difficult to define in advance given that there are numerous variables that impact the capitation rates and would need to be taken into consideration. Without being overly prescriptive we believe that the risk margin would be the starting point for evaluating whether a modification would be necessary and that such consideration would be equivalent for the cases of both over and underpayment. There could be scenarios where the trigger could be higher or lower than the risk margin such as large scale utilization shifts that impact the overall profitability of the MCOs either positively or negatively resulting in variations in other assumptions that offset the need to adjust rates retroactively.

2. Since CMS evaluates actuarial soundness at a rate cell level, we would appreciate understanding if the state and actuary intend to review whether adjustments to the rates are necessary as a result of the reconciliation at a rate cell level. If not, we would appreciate understanding why not, and at what level the state intends to perform the analyses to determine if adjustments to the rates are necessary.

   State Response (10/22/2021): Our intent would be to evaluate the need for any rate adjustments at the same level of detail on which the capitation rates are set, i.e. at the MCO, SDA and risk group level.

3. To the extent the state and actuary determine that adjustments to the MCO capitation rates are necessary as a result of the reconciliation, we would appreciate understanding if the state intends to still include a risk margin provision in the revised QIPP amounts included in the rates based on the reconciliation. If the state intends to still include a risk margin when developing revised QIPP amounts based on the reconciliation, we would appreciate understanding why this is reasonable.

   State Response (10/22/2021): In general, risk margins are set by program and applied uniformly across all components of the premium rate, i.e. medical, pharmacy, QIPP, CHIRP, etc…The margins are not necessarily intended to reflect the risk associated with each individual claim type, risk group, SDA but an aggregate reflection of the risk across the entire program inclusive of all services and rate components. For this reason, we believe that a risk margin may still be necessary as this assumption is set in aggregate and not specific to the QIPP. This assumption may need to be reevaluated given the specific circumstances in the event a rate adjustment is necessary.

2. Require that any payments based on performance are made only for facilities that achieve year over year improvement in accordance with the regulatory requirement that the arrangement must advance managed care quality goals and objectives.

State Response: MDS-based quality measures in Component 3 include improvement-over-self-targets as well as program-wide targets. As indicated in the pre-print Q&A, program-wide targets are meant to incentivize the participation of smaller facilities, where natural population fluctuations lead to wider variance in quarterly performance tracking, and already high-performing facilities, where there is less room for sustained improvement-over-self.

	a. Does CMS recommend HHSC remove quarterly measurement cycles and rely only on averaged or annual improvement for all participating facilities? **CMS Response**: Our primary concern for QIPP Component 3 is the OIG audit finding that nursing facilities that declined in performance continued to receive quality improvement incentive payments. With the state's new quarterly improvement schedule for Component 3 based on either 5% improvement over self or the national average, we still have concerns that there could be instances where a nursing facility has a *significant* decline in performance but the facility would still receive the quality improvement incentive payment by performing at or better than the national average. We understand that there may be natural fluctuations in provider performance; what we want to address with the state are these instances when there is a notable decline in performance and yet the provider still earns a quality incentive payment because they satisfy the national average benchmark. For QIPP Components 2 and 4, the state is using benchmarks only for these measures and not factoring in improvement over self. While this is acceptable, we do caution the state that such an approach can lead to the same issues raised by the OIG report if the benchmarks are not set appropriately. We would strongly advise that the state consider adding some threshold for at least maintaining or improving performance. CMS believes the only way to address this concern would be that for all components where payment is conditioned upon performance on a quality measure and the state wants to use a set benchmark that a provider must achieve to earn payment (e.g., a statewide or national benchmark), the state adopt a requirement that if the provider already was achieving the benchmark at the start of the performance period, they would have to demonstrate improvement or maintenance in period over period performance (e.g., year over year or quarter over quarter.) We recognize that there may be high-achieving providers that already surpassed the benchmark and show moderate fluctuations in performance that are natural fluctuations in performance. To address this, we would recommend that when measuring performance over self, the state allow for maintaining performance within the trend for the national benchmark for each measure. For example, if the national or statewide benchmark dipped by 1% from the previous period to the current period, providers who are already over the benchmark and maintained their performance measured at the individual facility level within a margin of +/-1 percent or improved by more than that would earn payment; if the same facility declined in performance by more than 1%, they would not receive payment even if their performance is over the benchmark. State Response: The state acknowledges CMS' suggestion to use the absolute change in the national average to set an allowed fluctuation for each MDS-based quality measure. HHSC proposes to calculate the variance for each measure at the beginning of the program year, relying on the Care Compare data used to set the baselines and benchmarks. The methodology could include using the four preceding quarters published alongside the 12-month average to calculate allowed quarterly variance. The state publishes final targets for each NF and measure at the beginning of the program year, in accordance with program rule; calculating the ad hoc variance each quarter would prevent state NFs from knowing their performance targets ahead of time.

CMS Response (9/24/2021): The state's response is unclear. CMS was suggesting that the state revise the requirements of the payment arrangement such that if the provider began the performance period above the national average, they would be required to show improvement over self, which could be defined as the facility maintaining performance (which could include a margin defined by the trend for the national benchmark.) Such an approach would not seem to prevent providers from knowing their performance target ahead of time. Can the state clarify its concerns and if it is able to make such an update to the preprint?

State Response (9/29/2021): The state's previous response was attempting to confirm that CMS was referencing an annual calculation with the phrase "For example, if the national or statewide benchmark dipped […] from the previous period to the current period." The change from the previous period to the current period will be calculated annually as the change from the previous program year's initial benchmark to the current year's benchmark.

The state proposes to add the following to the preprint: To account for natural fluctuations in quarterly performance results while still holding NFs accountable for incremental improvement, the state will define an allowed margin for each quality metric in Component 3. Any metric will be considered "Not Met" for the quarter if a NF performs worse than its initial baseline by more than this margin. Each metric's margin will be defined as the relative +/- change in the national average for that metric from the previous program year to the current program year.

CMS Response (10/18/2021): CMS received a revised preprint for QIPP on 10/13/2021; we are reviewing the changes discussed on 10/15 and will follow-up if there are any additional questions.

State Response (10/22/2021): Thank you for this update.

b. Does CMS expect the state to select one year as the baseline for that program year and subsequent years (e.g. FY 2021 baseline would be used not only to evaluate FY 2022, but also FY 2023, 2024, etc.) or can the baseline be set at the start of each program year (the method used in QIPP since year 1)? **CMS Response:** For establishing baselines for pay for performance measures where payment is conditioned upon performance, the baseline can be set at the start of each program year (or each quarter if the state chooses to continue measuring performance quarterly when determining payment).

For evaluation purposes, CMS expects the state to select one year as the baseline and it should be consistent for subsequent years. The November 2017 CIB provided further guidance on the quality requirements for directed payment proposals to include baseline data and improvement targets for performance measures. This was reiterated in the January 2021 SMDL and the revised preprint form. To best demonstrate improvement over time, SDP quality evaluations should always have a baseline that is before Year 1. Having the baseline set before Year 1 allows the state and CMS to understand the SDP's impact over time, as well as the ability to identify trends and allow continual adjustments to improve the program. If that is not possible, states

should at the latest use baseline data for the most recent period available (e.g., Year 1). In such instances where states cannot use baseline data before Year 1, baseline data should be submitted six months after the end of the first-year rating period. Additionally, to better understand trends in performance, baseline data should be consistent across years for payment arrangements that are operated over multiple years (even if approved annually).

State Response: Thank you for clarifying. This is in line with our submitted Evaluation Plan and performance measurement methodology.

c. Would CMS consider SDPs with performance-based components that use structure or process measures, or are outcome measures the only acceptable type of measures? For example, QIPP Component 2 recognizes increased nurse hours. **CMS Response:** CMS strongly encourages states to use outcome measures for value-based payments. While the use of Component 2 measures is permissible under the regulations at this time, using a Network Adequacy "count" such as the impact of increasing nursing hours, does not necessarily lead to health improvements for Medicaid beneficiaries. Using structure or count measures along with outcome measures can, however, show the importance of ensuring adequate staffing on health outcomes of beneficiaries, especially when done over time. We encourage Texas, therefore, to use these measures along with outcome measures that are measuring the impact of the healthcare. Also process measures, such as vaccine administration, can be used with outcome measures.

State Response: The submitted Evaluation Plan includes claims-based outcome measures regarding hospitalizations, which augment the RN coverage measures used in Component 2 as a way of showing impact and importance.

CMS Response (9/24/2021): Thank you for the state's response. To clarify, CMS' guidance to pair structure or count measures with outcome measures was referencing the condition of payment rather than just evaluation. The QIPP payment arrangement includes both outcome measures (such as those in Component 3) with the measures in Component 2. While CMS does encourage the state to pursue more outcome measures for future years, the current sets of measures is permissible under the regulations at this time.

State Response (9/29/2021): The state thanks CMS for the clarification, and the state will continue in accordance with the arrangement submitted in the preprint.

3. Refine the evaluation plan for QIPP to ensure that the effect of the QIPP state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.

State Response: It is the state's goal to have improvement year over year and to evaluate annual performance for participating facilities. The QIPP Performance Review submitted with the SFY 2022 pre-print includes analyses of the first three program years and demonstrated year-over-year improvement. Likewise, the QIPP Evaluation Plan submitted with the SFY 2022 pre-print includes a methodology of analysis that measures participating facilities

	individually and as a group against previous year performance. Some individual, MCO-designed value-based payment agreements with individual nursing facilities (NFs) may exist but QIPP is the only state-wide payment program focusing on NFs. For structure and process performance measures, the state planned to use SFY 2022 data as a baseline for future years. a. Does CMS have specific recommendations for how to isolate the impact of DPP from other state-wide initiatives? **CMS Response:** The state may consider involving their EQRO contractor or 1115 external evaluator to support this assessment. QIPP has the unique advantage to the other Texas SDPs of using the Medicare Minimum Data Set (MDS) 3.0 data collected by Texas Medicaid. MDS is standardized assessment data used for facilitating care management in all state nursing homes. We would recommend the use of the MDS raw data Texas is mandated to collect as the best source for their QIPP quality evaluation. We understand this has programming implications and will take time to implement. CMS will work with the state to find an agreed upon timeline for using MDS raw data for the evaluation. The state may also consider including qualitative analyses in their evaluation. Please see the discussion at the beginning of this paper regarding qualitative analysis. State Response: The state will explore possibilities for including the EQRO in the QIPP evaluation process and will obtain estimated timelines and costs for transitioning to using raw data. **CMS Response (10/18/2021):** We understand that the QIPP evaluation plan will be standalone, whereas there will be a single evaluation plan for CHIRP, TIPPS, BHS, and RAPPS. Please confirm. **State Response (10/22/2021)**: Yes this is correct.
Comprehensive Hospital Increase Reimbursement Program (CHIRP)	1. CMS does not consider the current aggregate payment amounts to be reasonable and appropriate, and CMS is concerned that the resulting capitation rates are not actuarially sound. Additionally, the state must provide a complete reimbursement analysis with a comparison to the average commercial rate for hospitals that only participate in the UHRIP component of the state directed payment. This reimbursement analysis must include hospital-specific reimbursement data as compared to the average commercial rate by hospital for the hospitals participating only in the UHRIP component. **State Response:** Aggregate Payment Amounts: Texas understands that CMS has approved directed-payment programs in other states using a comparison to the estimate of what an average commercial payor would have paid for the same services. To develop an estimate of an ACR upper payment limit, in consultation with CMS, Texas designed CHIRP to utilize a payment-to-charge ratio that is identical to the method used to calculate the estimate of Medicare payments for the same services. Texas

	understands from its call with CMS on August 20, 2021 that the proposed CHIRP would be the largest payment by gross dollars approved by CMS and that the year-over-year increase from FY2021 UHRIP to the proposed FY2022 CHIRP is a significant percentage increase. Texas notes that Medicaid generally requires reimbursement rates to be economic and efficient, but sufficient to attract enough providers for a Medicaid beneficiary to have equivalent access to a provider as an individual who is not in the Medicaid program. Because of this, reimbursement rates on a per service or per provider basis are generally understood to consider comparators to determine a reasonable and appropriate level of reimbursement. On Texas' call with CMS on August 24, 2021, CMS confirmed that typical comparators examined to evaluate reasonableness include Medicare, average commercial rates, and Medicaid Fee-for-service. We indicated that in Texas Medicaid FFS represents less than 4% of our population and for that reason, we feel that a more appropriate comparator is either Medicare or Average Commercial. CMS also noted that there may be variation in appropriateness of payment amongst payers for a variety of reasons; Texas agrees, specifically as it relates to Medicare. Texas' Medicaid population is primarily children and pregnant women who are not typical Medicare populations. For this reason, for hospitals in Texas, such as Children's hospitals, or urban hospitals that have high levels of maternity and neonatal care, Medicare may not be the most appropriate comparator and average commercial is likely the most appropriate comparator. Additionally, as discussed on the August 24, 2021 call, reimbursement rates generally incorporate some contemplation of the aspects of the provider market. As CMS is aware, with the discontinuation of DSRIP in FY2022, hospital payments in Texas will decline by more than $1.6 billion. Inherently, this means that the provider market, including willingness to serve Medicaid clients at prior rates, will not be comparable between FY2021 and FY2022. For this reason, Texas does not believe a year-over-year comparison of aggregate Medicaid managed care costs is appropriate. Actuarial Soundness of Capitation Rates: It has been Texas's long-standing understanding that actuarial soundness practices and principles for setting capitation rates applies to providing reasonable and appropriate provision to Managed Care Organizations congruent with costs and risk under the contracts. HHSC submitted actuarial certification reports to CMS on July 16, 2021 that included the CHRIP add-on rates for FY 2022. The actuarial opinion outlines the actuarial practices and principles applied to arrive at actuarially sound rates for the inclusion of the CHIRP, should CMS approve the program as submitted. In recent discussions, CMS is also applying actuarial opinions to aggregate Medicaid managed care spending. HHSC is not aware of federal guidance or direction for the actuary to provide an opinion on provider rates nor aggregate spending. In the August 24, 2021 call, CMS clarified that the review by OACT was made in the context of the pre-print review, and not the evaluation of the capitated rate submission. CMS further clarified that the questions and concerns at this time were more focused on the reasonableness of the underlying provider reimbursements and were not regarding the actuarial soundness of

	the capitated rates. Texas appreciates this clarification and agrees that there are not currently actuarial soundness concerns with the calculated capitated rates. Reimbursement Analysis: Texas also understands that CMS typically analyzes the reasonableness of the impact of state-directed payments on a per class basis, rather than on an individual provider basis, as illustrated in the pre-print template question 23. CMS confirmed this understanding on the August 24, 2021 call. Texas is of course willing to provide to CMS an analysis of the individual hospitals that are UHRIP participants only, for those providers who furnished to Texas the data necessary to calculate an ACR UPL. Please find it attached in Attachment A. Texas did not receive ACR data in the application from 17 hospitals, as providing such data was optional for providers at the time of the application. Texas seeks CMS guidance on whether CMS would allow Texas to obtain the data from these providers within 4 months of the program effective date with the condition that if the data is not received in that time frame, these providers would be removed from CHIRP, or alternately whether these providers can merely be restricted from participation in ACIA, as was originally planned. Texas would be willing to seek the data from the providers and furnish it to CMS as part of the monthly ongoing oversight calls that are supposed to occur between CMS and Texas pursuant to STC 36. Next Steps: While Texas continues to believe that the initial proposal and the underlying provider reimbursements on a per class basis are reasonable and appropriate, Texas would like to work with CMS collaboratively to achieve an approval for SFY 2022. Texas would be willing to impose a cap of 90% on the aggregate percentage of ACR that a hospital class can receive. This would reduce the total estimated program size to approximately $4.7 billion and would ensure that on an aggregate class basis, payments are at least 10% lower than ACR. Would CMS agree that this approach resolves any outstanding concerns about reasonableness of the payments and actuarial soundness? While the ACR data from 17 providers would be absent for this methodology based upon the data we have, they would be represented in the aggregate calculation as having an ACR UPL of $0 and thus their inclusion would have the effect of creating a lower aggregate ACR UPL cap because there would be no amount included in the denominator, though these providers would be included in the numerator. If so, Texas will submit a revised pre-print to this effect immediately. **CMS Response (11/10/2021)**: Related to the proposed sizing of CHIRP, payments under which the state has agreed to limit to no more than 90% of ACR, we have no additional concerns or questions about the size of the program. However, we remain concerned about the underlying financing of the CHIRP payments. **State Response (11/15/2021):** Thank you for confirming that our submitted pre-print methodology is approvable; we are glad that this matter can be considered resolved for the purposes of consideration of the pending CHIRP approval. **CMS Response:**

a. For the Reimbursement Analysis, CMS appreciates the state providing the additional data in Attachment A on the hospitals in UHRIP only.
   1. Can the state please confirm that we have accurately identified the 17 hospitals who have not provided ACR data to-date?

#	NPI	PROVIDER NAME
1	1205900370	HARRIS COUNTY HOSPITAL DISTRICT
2	1871917971	SAN ANTONIO BEHAVIORAL HEALTHCARE HOSPITAL, LLC-
3	1215354899	WESTPARK SPRINGS LLC-
4	1821025990	MEMORIAL HOSPITAL
5	1275956807	GEORGETOWN BEHAVIORAL HEALTH INSTITUTE, LLC-GEORGETOWN BEHAVIORAL HEALTH INSTITUTE LLC
6	1750620456	OCEANS BEHAVIORAL HOSPITAL OF ABILENE LLC-
7	1740791748	WOODLAND SPINGS LLC-WOODLAND SPRINGS
8	1114435260	CROCKETT MEDICAL CENTER LLC-CROCKETT MEDICAL CENTER
9	1174021695	REHABILITATION HOSPITAL LLC-UT HEALTH EAST TEXAS REHABILITATION HOSPITAL
10	1326349986	SCOTT AND WHITE HOSPITAL - LLANO-BAYLOR SCOTT AND WHITE MEDICAL CENTER - LLANO
11	1184056954	ROCK SPRINGS, LLC-
12	1538150370	SHAMROCK GENERAL HOSPITAL
13	1134401466	CARROLLTON SPRINGS LLC
14	1366880627	MESA SPRINGS, LLC-
15	1821612284	Kindred BH Acquisition 1, LLC d/b/a WellBridge Hospital Greater Dallas

16	1285258640	Kindred BH Acquisition 2, LLC d/b/a WellBridge Healthcare Fort Worth
17	1942795133	Ascension Seton Bastrop

State Response: Yes, Texas confirms these are the 17 hospitals that did not provide ACR data as part of the CHIRP application process.

2. If CMS were to grant the state the 4 months proposed to collect the outstanding ACR data for the 17 hospitals that would receive payments under UHRIP only, what would those hospitals be paid in the interim? If the ACR data from these 17 hospitals resulted in changes to the class percentage paid under UHRIP, how would the state implement such changes? Would such changes be retroactive to the start of the rating period? If the hospital(s) fail to provide the data, would the payments made during this 4-month period be recouped by the plan and the state?
State Response: HHSC anticipates that the 17 providers will comply with our request for the additional data, as we will work with them to help them understand that furnishing the data is an expectation from CMS for approval of the program. Those hospitals would continue to be eligible for payments under UHRIP as the payment calculation for all hospitals in a class is based upon the Medicare UPL demonstration, for which we are not lacking data. If upon receipt of the ACR data from the 17 hospitals there is a reduction to the available 90% aggregate ACR cap that HHSC has proposed, we anticipate the state would submit for CMS consideration a mid-year adjustment to decrease rates for the impacted class to ensure that the provider payments stay under the cap. If a hospital fails to furnish the data required by CMS, HHSC would remove those hospitals from the program, if that is what CMS would require under the terms of this agreement, but requests that if that is required that the modification be applied prospectively as a mid-year adjustment.

Texas notes that these hospitals represent approximately 1% of provider payments in CHIRP as originally proposed, so Texas does not anticipate that these hospitals' data will make a material difference in the program calculations.

CMS Response 9/24/21: If the state will need to make modifications to the uniform increases for these 17 hospitals, can the state clarify if the adjustments would be implemented consistently with the effective date of CHIRP (i.e. likely back to the beginning of the fiscal year 2022/September 1 2021), but compressed into a shorter prospective time period? Or would the state make modifications to the uniform increases from a point within the rating period going forward and not back to the effective date of CHRIP?
State Response (9/29/2021): HHSC reiterates that we anticipate the 17 providers will comply with our request for the additional data, as we will work with them to help them understand that furnishing the data is an expectation from CMS for approval of the program. We have already had outreach from

some of the providers asking what data they need to furnish to begin the process. If a hospital fails to furnish the data required by CMS, HHSC would remove those hospitals from the program, if that is what CMS would require under the terms of this agreement. But HHSC requests that such modification be applied prospectively as a mid-year adjustment. If the adjustment is implemented as a mid-year adjustment, the state proposes to make modifications from that point in the rating period going forward rather than back to the effective date of CHIRP. However, HHSC seeks CMS guidance on what CMS would require for the program to be considered approvable.

CMS Response (10/18/2021): Can the state please provide an update on the 17 hospitals and if they have agreed to provide the requested data?

State Response (10/22/2021): We have not yet solicited agreement from the 17 providers at this point, though some have contacted the state to ascertain specifications of what data will be required, if CMS requires Texas to implement this. Prior to making a request for data, Texas would like to be able to clarify for providers the consequences of potentially failing to submit to the data, and waits for CMS to issue guidance, pursuant to our response from September 29.

CMS Response (11/10/2021): CMS' position is that should a hospital fail to provide their respective ACR data, that hospital would no longer be eligible for CHIRP payments and any modificiations to the capitation rates would go back to the effective date of CHIRP. The state could make CHIRP payments to these providers in the interim until the hospital provides the ACR data and subsequently collect any recoupments as necessary, or alternatively withhold payment to the hospital until the ACR data is provided. To the extent the state determines that a mid-year adjustment to the capitation rates is necessary, the state should implement these adjustments back to the effective date of CHIRP (if this is consistent with the effective date of the changes to the uniform increases to providers), rather than making modifications to the rates from the point of the mid-year amendment going forward.

State Response (11/15/2021): Thank you for providing clarity on CMS' expectations for the consequences of failure to submit ACR data from the 17 hospitals. Texas will send formal requests to the hospitals to submit the data immediately following CMS approval of the pending pre-print.

b. Please confirm in writing the following from the call on 8/30:
   1. The data provided in the third tab of Attachment A sent on 8/25 for the hospitals that receive both ACIA and UHRIP is the same as the data provided in Attachment C during the third round of responses?

      State Response: The data is the same. There is, however, an inadvertently duplicated hospital on Attachment C, CHIRP Payment Calc tab, line 422. The average CHIRP rate in Attachment C does change slightly for Urban Lubbock. It changes from 72% to 80% for inpatient CHIRP and from 143% to 150% for outpatient CHIRP.

2. For hospitals participating in only UHRIP and not ACIA, there are 106 hospitals that would be receiving payments above the average commercial rate?
   State Response: In the original CHIRP proposal, 106 hospitals would receive UHRIP inpatient rate increases that result in those hospitals receiving payments above their individual inpatient ACR. However, 83 hospitals would receive UHRIP outpatient rate increases that result in those hospitals receiving payments above their individual outpatient ACR. There are 32 hospitals that receive both inpatient and outpatient increases that result in those hospitals receiving payments above their individual outpatient ACR. However, Texas understands and agrees with CMS' approach to analyze the reasonableness of the impact of state-directed payments on a per class basis, rather than on an individual provider basis, as illustrated in the pre-print template question 23. CMS confirmed this understanding on our August 24, 2021 call.

CMS Response (9/24/2021): CMS is still considering if the revised payment arrangement is reasonable and appropriate. CMS has not seen payment arrangements designed with the complexity of Texas', particularly in terms of the number of classes and the application of percentage increases differing from a class level in one component of the program (UHRIP) to an individual hospital level in another component (ACIA). CMS' understanding from calls has been that the same number of hospitals would receive UHRIP payments above the individual ACR levels for inpatient (106 hospitals) and outpatient (83 hospitals) as described above. Can the state confirm this?
State Response (9/29/2021): Texas agrees that the programmatic structure discussed is innovative and complex. Texas implemented the original UHRIP in December 2017 and has worked each year to improve the program; it is natural that the program being proposed for September 2021 is significantly more complex, sizeable, and mature. With respect to the number of classes, Texas notes that in CMS' State Medicaid Director letter 21-001 (SMD #21-001), CMS said, "As stated in the May 2020 CIB, historically, **CMS has deferred to states** in defining the provider class for purposes of state directed payment arrangements, **as long as the provider class is reasonable and identifiable, such as the provider class being defined in the state's Medicaid State Plan.**" (emphasis added). Texas has adhered very closely to the Medicaid State Plan class definitions but has incorporated the additional geographic criteria of the Service Delivery Areas that are pre-defined for Medicaid managed care. Additionally, according to the American Hospital Association, in 2021, Texas has the highest number of community hospitals in the nation; California, which has 40% fewer hospitals, is a distant second. It is consistent with the size and diversity of the state that there are many hospital classes in the proposed program.

Additionally, in SMD #21-001, CMS stated that they have "required states to demonstrate that the state directed payments result in provider payment rates that are reasonable, appropriate, and attainable…To do this, CMS has required an analysis from states to understand the relative effect of the directed payment on reimbursement for **each service type and each provider class** receiving the state directed payment(s)." (emphasis added). Texas understands that CMS is continuing their review of Texas' proposed modifications to the program design but anticipates that when review of each service type and each provider class is complete, the proposed payment amounts will be determined to be reasonable.

Regarding the number of hospitals that would receive UHRIP payments above the individual ACR levels, the totals are still 106 hospitals for inpatient and 83 hospitals for outpatient.

3. There was one hospital that appeared to be included in the Round 3 responses (Attachment C) that was missing from Attachment A sent on 8/25 – TPI #1154893675 labeled "Health" in the Urban Lubbock class/SDA. Was this an omission or did the provider decide to no longer participate?
   State Response: The duplicated hospital in Attachment C was corrected for the Attachment A submission.

4. During the call, CMS noted that it appeared there may be an increase in outpatient payments for CHIRP driven by the UHRIP only hospitals from $456M to $659M. Can the state confirm in writing if there was an increase and if so, what the cause of the increase was?
   State Response: In Attachment C to the third-round responses, Texas showed on Tab "CHIRP Payment Calc", cell W3, a UHRIP outpatient reimbursement amount of $659 million. There is no change to the amount in the original proposal for CHIRP. $456 million is the subportion of the $659 million UHRIP outpatient amount that is associated with hospitals that also receive ACIA payments. Texas reiterates the offer made in its proposal submitted on August 25, 2021 to cap payments at a 90% aggregate ACR for the class.

5. In tab 1 of Attachment A sent on 8/25, CMS's understanding is that nearly all the classes for either inpatient or outpatient hospital services would receive payment above the ACR when the analysis is limited to hospitals within the class that are only receiving UHRIP and not ACIA, correct? For example, Urban hospitals in Harris SDA that are only participating in UHRIP would receive increases that are expected to bring total reimbursement up to 280% of the Average Commercial Rate.
   State Response: Yes, this is correct, but Texas thinks it is inappropriate to subdivide the class in this manner as the analysis is not a complete picture of the reasonableness of payments to the class. Texas understands and agrees with CMS' approach to analyze the reasonableness of the impact of state-directed payments on a per class basis, rather than on an individual provider basis, as illustrated in the pre-print template question 23. CMS described this approach on the August 24, 2021 call. Texas reiterates the offer made in its proposal submitted on August 25, 2021 to cap payments at a 90% aggregate ACR for the class.

c. We noticed during the preprint review process that the impact of the NAIP pass-through payments appears to have changed for several classes between the analyses provided for Round 2 and Round 3. Can the state please clarify if the NAIP amounts provided in Attachment A, tab "All Hospitals by Class", include the most accurate NAIP amounts to-date?

State Response: The largest contributor to the change in NAIP payments is that the University of Texas Southwestern Medical Center (TPI #175287501) had their physician NAIP payment included in the CHIRP analysis initially. The hospital informed Texas HHSC of the error, and the approximately $19 million NAIP payment was removed from the analysis. There were also some smaller variances due to the usage of different data sources for the NAIP payment data. To be consistent, HHSC has used the NAIP payments included in the 2021 Medicare UPL tests as the basis for NAIP payments in this analysis.

CMS Response (9/24/2021): CMS appreciates the state's clarification. Was the $19 million physician NAIP payment accounted for in the payment level analysis provided as part of the TIPPS proposal? Or is the University of Texas Southwestern Medical Center not eligible for the TIPPS state directed payment?
State Response (9/29/2021): The $19 million physician NAIP payment to UT Southwestern was accounted for in the payment level analysis provided as part of the TIPPS proposal.

d. The 90% cap the state has proposed would apply across CHIRP payments, correct? CMS' understanding from the 8/30 call is that the state would take the following steps in calculating the 90% cap:
    1. Calculate the Medicare UPL gap for the class/SDA (Urban Hospitals in Bexar) for inpatient and outpatient services separately.
    2. Determine a percentage increase for the class/SDA for UHRIP.
    3. Calculate the ACR gap for the class/SDA.
    4. Apply the 90% cap to the ACR gap for the class/SDA.

    State Response: Yes, this is correct, unless the Medicare UPL for a class exceeds 90% of the ACR, in which case a hospital class would be eligible to receive payments under UHRIP, but no hospital within the class would be eligible for increases under ACIA.

e. Under the 90% cap, hospitals would receive up to the UHRIP % increase determined by the Medicare UPL gap first before additional funds would be divided up to pay the additional increase under ACIA, correct?
    State Response: Yes, this is correct, unless the Medicare UPL for a class exceeds 90% of the ACR, in which case a hospital class would be eligible to receive payments under UHRIP, but no hospital within the class would be eligible for increases under ACIA.

f. If a hospital receives an increase under UHRIP that exceeds their ACR, they would continue to receive the full UHRIP increase under the 90% cap proposal, correct?
    State Response: Yes, this is correct. Texas understands and agrees with CMS' approach to analyze the reasonableness of the impact of state-directed payments on a per class basis, rather than on an individual provider basis, as illustrated in the pre-print template question 23. CMS described this approach on the August 24, 2021 call.

g. To proceed with the state's proposal to impose a cap of 90% on the aggregate percentage of the ACR that a hospital can receive, CMS will need the state to provide the actual uniform percentage increases for each hospital class and SDA for UHRIP

and for each hospital for ACIA being requested under the preprint. The state will also need to provide an updated reimbursement analysis based on these new UHRIP and ACIA uniform percentage increases. This reimbursement analysis should show the impacts of the uniform percentage increases for both UHRIP and ACIA and across all hospitals.

State Response: HHSC has completed the analysis and it can be found in the Attachment labeled "CHIRP_9.10.21_90% ACR.

CMS Response (9/24/2021):

1. CMS was unable to locate the file referenced here titled CHIRP_9.10.21_90% ACR. Is the information requested in this question available in 4.2 Attachment C – CHIRP Rate Estimates and Payment Levels? If not, can the state provide this attachment?
   State Response (9/29/2021): Yes, this information is included in the new Attachment C that was submitted on September 15, 2021.
   CMS Response (10/18/2021): We understand that the Attachment C that was submitted to CMS on 9/29/21 had no substantive changes compared to the 9/15/21 version. The only changes in the 9/29/21 version are how the tabs are labelled. Please confirm.
   State Response (10/22/2021): Yes this is correct.

2. Can the state also confirm if the analysis in the attachment labeled 4.2 Attachment C – CHIRP Rate Estimates and Payment Levels accounts for the final percentage increases for each component of CHIRP (UHRIP and ACIA) under the 90% proposal?
   State Response (9/29/2021): Yes, the state confirms that the analysis under tabs "IP CHIRP Payment Levels – All" and "OP CHIRP Payment Levels – All" includes all hospitals and all components.
   CMS Response (10/18/2021): We understand that Attachment C includes all hospitals and components, but can the state please confirm too that Attachment C reflects the final percentage increases under each component under the 90% proposal.
   State Response (10/22/2021): Yes this is correct.

3. The revised preprint for CHIRP, the state's response in Table 2 says to refer to the "Provider Payment Analysis" tab of Attachment C. However, the latest version of Attachment C does not have a tab entitled "Provider Payment Analysis". Please update the preprint and/or Attachment C appropriately.
   State Response (9/29/2021): The pre-print has been updated appropriately.

2. Refine the evaluation plan for CHIRP to ensure that the effect of the CHIRP state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.

State Response: The state is working with our EQRO contractor to refine an attribution methodology for each program. There are some measures included in the evaluation which cannot be limited to providers participating in the DPP. Some of the measures that cannot be attributed exclusively to one DPP provider are CMS core set measures recommended by CMS for DPP evaluations. In light of the call on 8/24 and CMS' acknowledgement, we will proceed

with maintaining the CMS core set measures selected for the respective evaluations, even though they cannot be attributed only to providers participating in the corresponding DPPs. HHSC is also open to providing one annual DPP evaluation which breaks out DPP-specific attribution measures, as suggested by CMS in the August 24, 2021 call with Texas.

a. Does CMS have any other recommendations for how to isolate the impact of the DPP other than the work HHSC is undertaking with its EQRO contractor to do so?

CMS Response: Please refer to the overarching comments at the top of this paper.
State Response: Please refer to our responses to CMS's overarching comments.

With respect to baseline year, in a phone call on January 27, 2021 with CMS, HHSC proposed using CY 2020 and CY2021 as baselines because of the timing of the beginning of the program (CY 2021 would include 4 months of the start of the program) and the impact of COVID. Using the two years was intended to capture that context for future measurement. CMS indicated the proposal made sense. If CMS prefers that we use only one year, HHSC could use CY 2021 for the new CHIRP evaluation measures. However, this would delay further any evaluation of the programs because of data lags (please see page 6 of the CHIRP updated evaluation plan for timeline of available data).

With respect to year-over-year improvement, it is the state's goal to have improvement year-over-year, but we are also cognizant of not being able to set goals at this point because of the unknown impact of the PHE.

a. Does CMS have a recommendation for how the state can address this issue in the evaluation plan?

CMS Response: CMS recognizes all healthcare systems have been impacted by COVID and that year-over-year improvement will be challenged by the PHE. We take that into consideration in our review of quality improvement efforts. We anticipate that the PHE will be part of the narrative and outcomes of the SDP evaluations including how COVID impacted the evaluation findings.
State Response: We will add this discussion to the evaluations. Does CMS have concerns with the goals and targets we have included in the plans?

CMS Response 9/24/21: Our concern is that the state has not identified any overall quality improvement targets for the SDPs. The state will need to provide those overall quality improvement targets (for each measure) for SFY 2023; that timeframe allows the state to see 2021 data and adjust for COVID.
State Response (9/29/2021): As acknowledged by CMS, the SFY2022 preprints will not include improvement targets as baseline data is pending. The State will include initial improvement targets for achievement in CY2022 in the SFY2023/Year 2 preprint submissions. However, the State may submit an addendum to update these improvement targets during SFY2023 after CY2021 data are available (estimated in summer/fall 2022).
CMS Response (10/18/2021): We understand from the October 4, 2021 call that the targets included in the SFY 2023 preprint submission will take into account initial CY2022 provider-

	submitted data and that the addendum would take into account state-level measurement data from the EQRO. Is this understanding correct? **State Response (10/22/2021)**: The SFY 2023 preprint submission would take into account initial baseline CY 2021 provider-submitted data in order to set preliminary goals for improvement in the 2nd year of the program. The addendum would update the DPP-specific improvement goals, if needed, based on complete baseline CY 2021 provider-submitted data (which would not be received until April 2022 on currently proposed timelines). Although CY 2021 state level data from the EQRO will not be available until October 2022, HHSC could use historical state level data (incuding CY 2020) to set preliminary goals in the SFY 2023 preprint submission . Another SFY 2023 preprint addendum would update improvement goals, if needed, based on complete baseline CY 2021 state level data from the EQRO (which would not be received until October 2022). b. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable? **CMS Response:** CMS would agree to maintenance of a high-performance rate within a threshold above the national benchmark. The threshold percentage would need to align with the national trend for each measure as noted in response to the questions on QIPP above. State Response: As proposed, the first year of these programs (CHIRP, DPP BHS, RAPPS, and TIPPS) will establish baselines. As such, the state will not make these adjustments in administrative rule or the preprints at this time. Thank you for agreeing to maintenance of a high-performance rate. HHSC will consider the recommendation for its second-year program designs. The requirement to demonstrate year-over-year improvement is something that will be evident in the evaluation and structure of the second year of these programs. **CMS Response (9/24/2021):** CMS' understanding is that each of the preprints listed here have moved to include only uniform increases where payment is conditioned upon utilization and not performance. If any of these proposals condition payment upon performance, then changes to account for this will need to be made in alignment to feedback previously provided. See comments above related to QIPP. **State Response (9/29/2021):** The state confirms that CMS' understanding is correct, and payment is not conditioned upon performance in Year 1 in the four new, proposed SDPs.
Texas Incentives for Physicians and Professional Services (TIPPS)	1. Remove the 18% reconciliation threshold and base payments only on current utilization or performance measured during the rating period (rather than historical utilization or performance). **State Response**: We understand from the call between Texas and CMS on August 20, 2021, CMS will not consider Texas's proposal of a reduced threshold for SFY 2022, with a complete elimination of the structure for SFY2023. In an effort to achieve a pathway forward for this important program, Texas would like to utilize a payment structure where interim payments for SFY 2022 are based initially upon the historical utilization data, with final payments made based upon actual data at the end of the program year, with no contingency for a variation in utilization data. This approach will allow for consistent payments to be made through the program year, but final payments to be based exclusively on actual utilization.

Would CMS agree that this approach resolves any outstanding concerns about the tie to utilization? If so, Texas will submit a revised pre-print to this effect immediately.

CMS Response: What the state has described for SFY 2022 for TIPPS Component 1, where interim payments would initially be based upon historical information but reconciled to actual utilization during the rating period, would be permissible. We do have a few follow-up questions to ensure our understanding of this arrangement:
State Response: Thank you for this feedback; we are glad that this matter can be considered resolved for the purposes of consideration of our pending SDP approvals.

2. Please describe in more detail how the payments will be made under the state's new proposal to replace the reconciliation threshold. Please provide a step-by step breakdown for how payment will work for both the MCOs and providers -- including whether the interim payments will be based on the same monthly payment amount currently proposed in the preprint, when interim payments will be made based on historical utilization, how long such interim payments will continue to be made based on historical utilization, when the payments will be made based on actual utilization, and how the initial payments made based on historical utilization will be reconciled to actual utilization during the rating period. Please also discuss if the reconciliation could potentially result in recoupments from MCOs or providers.

   State Response: Please see Attachment A for a timeline and high-level description of the process. There will be three subprocesses required as part of this overall process. In the first subprocess, HHSC will pay MCOs a monthly actuarially sound capitated rate based upon actual caseloads each month. MCOs will adjudicate actual claims through normal processes and then submit to HHSC encounter data. Typically, due to claims processing timelines, encounter data for a rating period is usually considered substantially complete approximately 120 days after the end of the rating period, which for Texas means December 31, 2022 for the September 1, 2021 through August 31, 2022 rating period. In a separate subprocess, HHSC receives quality-related data from providers that is required as a condition of participation in the program. HHSC will direct MCOs to issue payments to providers based upon historical data and using funds received by the MCO in the monthly capitated rate that was paid. The MCO will issue the interim payment to the provider monthly. In the final subprocess, approximately 120 days after the end of the rating period, HHSC will reconcile the historical utilization that was used as the basis of the interim payments to the actual encounters reported by the MCOs. HHSC will then direct the MCOs to recoup from and redistribute funds to providers based upon the reconciled information. The MCOs will not experience recoupments as the capitated rates paid to the MCOs will include all necessary payments. Providers may experience recoupments or receive additional funds based upon historical-to-actual utilization fluctuations.

CMS Response (9/24/2021): CMS appreciates the additional information provided on the process. CMS would like to confirm the following:
State Response (9/29/2021): HHSC is happy to share additional information to confirm CMS' understanding of the reconciliation process. Per CMS' September 10, 2021 statement that the reconciliation process would be permissible under the regulation, we are glad that this

matter can be considered resolved for the purposes of consideration of our pending SDP approvals.

1. The 3 processes indicate that no changes will be made to the payments the MCO receives from the state; changes to the payments would occur for the providers within what the state has paid the plans, is that correct?
   State Response (9/29/2021): Yes, that is the intent. However, there may be modifications to MCO payments if the redistributions are significant to a point that the resulting adjustments would no longer be considered actuarially sound.

2. Does the state anticipate any amendments to the rates or rate certifications to account for the reconciliation requirement?
   State Response (9/29/2021): Not at this time.

3. How will the state inform the plans of any needed recoupments or redistributions of the funds to providers? Through updates to the contract?
   State Response (9/29/2021): The state will inform the MCOs via an updated payment scorecard that will show any provider level payment adjustments (positive or negative) that are required.

   CMS Response (10/18/2021): We understand that the payment scorecard has historically been used for payments to QIPP providers, and that the state will now include direction in the MCO contracts for using this scorecard for when recoupments or redistributions are needed for providers participating in TIPPS, BHS and RAPPS. Is this correct?
   State Response (10/22/2021): The state will create a scorecard specific to each program that is similar to the scorecard used in QIPP, but there will not be a consolidated scorecard for all programs. The program-specific scorecards will be used to indicate when recoupments or redistributions are necessary.

4. CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.
   State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

5. The response to Question 9a in the preprint indicates that the payment for Component 1 will be a uniform increase of $47.99 for class 1 and $29.15 for class 2. Can the state

confirm this is correct? Are the payments made under Component 1 to providers on a PMPM basis or on a per service (or per claim) basis? Would the amount paid for each class change with the reconciliation?

State Response (9/29/2021): Yes, those uniform increases are correct. The impact of the payment increase is the percentage identified on a per unique client or percentage of total claims basis; however, the state intends on making the payments as lump sum monthly payment during the program year, prior to the reconciliation to actual physician and professional claims at the end of the program period. The amounts could change as the state intends to maintain the size of components 1 and 2 as identified in the pre-print but would adjust the uniform increase per unique client served or the percentage of total claims if the actual utilization varies from the historical. The adjustment would take place at the time of the reconciliation.

CMS Response (10/18/2021):

1. It is still unclear to us if the Component 1 uniform increases would be paid on a PMPM basis or on a per service/per claim basis. Our understanding is that $47.99 for class 1 and $29.15 for class 2 are the uniform increase estimates on a per claim/service basis. However, the response to preprint question 19.b and Attachment L in the revised preprint indicates: "The following per member per month rates will be paid: $47.99 for class 1, $29.15 for class 2." Please clarify if the state intends to pay these funds on a PMPM basis (rather than on a per claim/utilization basis), including as part of the final reconciliation (i.e. applying the PMPM increase in the preprint to actual member months during the reconciliation).

   State Response (10/22/2021): Component 1 in TIPPS is designed to be paid based upon the number of unique Medicaid managed care clients served by the provider in proportion to the total number of unique Medicaid managed care clients served by all program participants. The total value of Component 1 for all providers is equal to 65% of the program value, paid monthly to each provider. HHSC intends, at the time of reconciliation, to recalculate all provider payments using the actual number of unique clients served by the provider as compared to the total number of actual unique clients served by all program participants. If the total value of Component 1 fluctuates, as a result of the total program value fluctuating as a result of caseloads, the per unique client monthly payment to providers in the pre-print would be scaled proportionately as well.

2. The state says, "The amounts could change as the state intends to maintain the size of components 1 and 2 as identified in the pre-print but would adjust the uniform increase per unique client served or the percentage of total claims if the actual utilization varies from the historical. The adjustment would take place at the time of the reconciliation."

   a. We understand from this response that the uniform increase amounts may change to ensure that the state maintains the size of components 1 and 2. Is that correct?

      State Response (10/22/2021): No, if the actual program size fluctuates as a result of caseload, the size of Component 1 would fluctuate proportionately as Component 1 is designed to be equal to a percentage of the overall program value. The reconciliation performed at the end of the program year will be performed to reconcile to the actual value of Component 1 based upon the actual value of the overall program as paid through the program year.

b. Our understanding from previous rounds of review is that the targeted amount for Component 1 is $366,600,000 and for Component 2 is $141,000,000. Can the state please confirm these are the amounts that the state intends to reconcile to? Will these targeted amounts include any provisions for administration, risk margin, and premium tax?

State Response (10/22/2021): The amounts identified for Components 1 and 2 are an estimate based upon the proposed program size. However, if the actual program size fluctuates as a result of caseload, the size of Components 1 and 2 would fluctuate proportionately as Component 1 and 2 are designed to be equal to a percentage of the overall program value. The reconciliation performed at the end of the program year will be performed to reconcile to the actual value of Components 1 and 2 based upon the actual value of the overall program as paid through the program year. All managed care capitated payments will include administration, risk margin, and premium tax, as appropriate. The Component 1 and 2 values listed above do not include any provisions associated with administration, risk margin, and premium tax.

c. Can the state please further explain what is meant by adjusting the uniform increase "per unique client" and confirm the retroactively adjusted uniform increase would still be the same for all providers in the class for each component.

State Response (10/22/2021): As described above, for Component 1, HHSC has calculated the provider payments to pay an equal amount for each unique client served by the provider historically compared to the total number of unique clients served by all providers. When the reconciliation occurs, the payments to each provider will be recalculated to ensure their payments reflect actual numbers of unique clients served. The per unique client value will reman uniform for all providers in the class.

d. Can the state please further explain what is meant by adjusting "the percentage of total claims", and confirm the retroactively adjusted uniform increase would still be applied to all eligible claims/services.

State Response (10/22/2021): HHSC has calculated the provider payments to pay a uniform percentage increase for all adjudicated claims paid to program participants historically. When the reconciliation occurs, the payments to each provider will apply a uniform increase to all actual adjudicated claims to ensure that the total value of Component 2 is still in proportion to the overall program value at 25%. This means that the uniform percentage increase may fluctuate proportionately to the program, but will remain uniform for all providers based upon actual adjudicated claims.

6. The state indicated on calls that the state intended to continue incorporating this payment arrangement as an adjustment to base rates rather than a separate payment term. Given the revised reconciliation process for Component 1, can the state affirm that it still plans to incorporate all components of this payment arrangement through an adjustment to base rates or would the state pay any part of this payment arrangement, such as Component 1, as a separate payment term?

State Response (9/29/2021): Yes, all components will be through an adjustment to base rates.

CMS Response (10/18/2021): The state indicates in the response to question 5 above that the uniform increases currently documented in the preprint would change at the time of the reconciliation as the state intends to maintain the size of Component 1 and Component 2 funding currently identified in the preprint. Is the state's goal under Component 1, Component 2 or any other component to ensure that exactly a certain amount (e.g., $366,600,000 for Component 1 and $141,000,000 for Compnent 2) is expended by the plans for payments to providers under any specific components? Or are the amounts listed for each component an estimate that is subject to change? If so, what would cause it to change?

State Response (10/22/2021): To clarify, the state intends to maintain the sizes of Components 1 and 2 as a percentage of the overall program value; however, the gross value of Component 1 may change if the overall program value fluctuates from the estimated value. This fluctuation would be a result of changes in caseload from the forecasted caseload for the fiscal year. However, the payments will still be reconciled against actual utilization, so the actual percentage of program value compared to actual utilization may result in a different percentage rate increase than the estimated rate increase, which is based upon historical utilization and estimated program values.

CMS Response (10/18/2021): Does the state direct the plans to set aside any portion of the capitation rate paid to them for this payment arrangement?

State Response (10/22/2021): No. The portion of the capitation rate attributed to each DPP has been separately identified and reported to the MCOs but no direction has been provided on how the MCOs should "set aside" these funds.

CMS Response (10/18/2021): Are the plans directed to use a specific portion of the capitation rates paid to them to pay out Component 1?

State Response (10/22/2021): No. The capitation rates have been calculated separately for each DPP; however, this add-on rate isn't delineated between the various components.

7. Please also revise the preprint to include the information on the reconciliation process described in Attachment A.

State Response (9/29/2021): All payments will be reconciled to actual utilization data during the final reconciliation. Attachment B.1, Reconciliation Process, has been incorporated by reference.

3. Can the state confirm that all payments (including the interim payments based on historical data) will be reconciled to actual utilization data during the rating period? Or will those initial interim payments remain based only on historical utilization?

State Response: All payments will be reconciled to actual utilization data during the final reconciliation.

CMS Response (9/24/2021): See CMS Round 3 responses, Question 4 above - CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments

initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.

State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

4. We will note that states that make interim payments based on historical utilization and then reconcile to actual data have noted that reconciliations like this can be administratively burdensome.

   State Response: Noted. The importance of the program to our healthcare safety net is significant so HHSC will absorb the administrative burden.

CMS Response (9/24/2021): See CMS Round 3 responses, Question 4 above - CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.

State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

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5. CMS' understanding from previous responses is that the reconciliation threshold is a part of the state's administrative code. Can the state confirm that this change can be implemented without changes to the administrative code? If not, can the state describe the process and timing for making such changes? If changes to the administrative code are needed, will the state be able to implement those retroactively back to the start of the rating period?

   State Response: Implementing this change will require the state to modify the Texas Administrative Code. HHSC will propose that rule changes will apply to the entire program period, though the effective date of the rule change will be subsequent to the start of the rating period.

CMS Response (9/24/2021): Can the state elaborate the timeframes that would be needed to complete the state rulemaking process? Can the state also comment on if they anticipate challenges to the rulemaking and what impact those would have on implementation timelines?
State Response (9/29/2021): The Texas rulemaking process requires filing of a proposed rule with the Texas Register by Monday at noon to have the proposal published 11 days later (the second Friday after submission). Proposed rules are generally posted for a 30-day public comment period. Following the public comment period, the rule can be adopted with or without changes. Typically, a rule takes effect 20 days after the date the rule is filed with the Texas Register. This total process requires a minimum of 51 days; however, accounting for time necessary to prepare the rules for publication, to review public comments and make any changes as a result thereof, HHSC typically assumes a minimum of 90 days will be necessary. HHSC anticipates receiving public comments, but also anticipates that providers prefer changes be made if they are necessary for a CMS approval for state fiscal year 2022.

For more information, CMS may wish to visit our webpage on rulemaking: https://www.hhs.texas.gov/laws-regulations/policies-rules/health-human-services-rulemaking.

CMS Response (10/18/2021): From the description above, it sounds like CMS would not expect rate amendments or contract amendments to implement the proposed changes until 90 days after the start of rulemaking at the state level. Is this correct?
State Response (10/22/2021): With respect to rule making changes described above, the state does not anticipate that rate changes or contract amendments would be required to implement the changes proposed for TIPPS, so the rates and contracts already filed with CMS will stand.

6. Can the state please describe how this new approach will be accounted for in the capitation rates? Will the directed payment continue to be incorporated into the rates as an adjustment to the base data or will the directed payment now be incorporated into the rates as a separate payment term? It would be helpful for the state to clarify how this new approach would impact the amounts included in the initial certification, and if the state and actuary intend to amend the rates in the future once the final payments based on actual utilization are known.

   State Response: We expect that the TIPPS would continue to be incorporated as an adjustment to the base capitation rates and included in the monthly premium. Once final data is available at the end of the year, a retroactive adjustment to the TIPPS capitation rates may be necessary, in which case HHSC would amend the MCO contracts and submit an actuarial rate amendment.

CMS Response (9/24/2021): See CMS Round 3 responses, Questions 1, 2 and 6. Appendix A, process 3 does not indicate that there will be any changes to the MCO payments and the state's response above states, "The MCOs will not experience recoupments as the capitated rates paid to the MCOs will include all necessary payments." However, this response indicates that retroactive adjustments to the capitation rates may be necessary. Can the state please clarify if the state expects or anticipates an amendment to the rates and rate certifications may be needed and under what circumstances?

State Response (9/29/2021): The state does not anticipate making any prospective capitated rate changes based upon this modification. However, once final data is available at the end of the year, a retroactive adjustment to the capitation rates may be necessary if the degree of recoupments and redistributions is significant to the point that the capitated rates are no longer actuarially sound. If that occurs, HHSC would amend the MCO contracts and submit an actuarial rate amendment.

CMS Response (10/18/2021): The state indicates that there may be modifications to MCO payments if the redistributions are significant to a point that the resulting adjustments would no longer be considered actuarially sound. We would appreciate better understanding under what circumstances the MCO rates would be revised.

1. Can the state and its actuary please discuss how you are defining "significant" in this instance, and what threshold would trigger adjustments to the MCO capitation rates. Please address both the potential instances when MCOs are required to pay out more TIPPS payments than the amount of funding included prospectively in capitation rates, and when MCOs are required to pay out less TIPPS payments than the amount of funding included prospectively in the capitation rates.

   State Response (10/22/2021): The intent of any reconciliation would be to ensure that all MCO capitation rates continued to be considered actuarially sound and to ensure that no MCO was inadvertently harmed (or profited) due to shifts in utilization and provider payments that are beyond their control. The threshold for triggering a retroactive rate change is difficult to define in advance given that there are numerous variables that impact the capitation rates and would need to be taken into consideration. Without being overly prescriptive we believe that the risk margin would be the starting point for evaluating whether a modification would be necessary and that such consideration would be equivalent for the cases of both over and underpayment. There could be scenarios where the trigger could be higher or lower than the risk margin such as large scale utilization shifts that impact the overall profitability of the MCOs either positively or negatively resulting in variations in other assumptions that offset the need to adjust rates retroactively.
2. Since CMS evaluates actuarial soundness at a rate cell level, we would appreciate understanding if the state and actuary intend to review whether adjustments to the rates are necessary as a result of the reconciliation at a rate cell level. If not, we would appreciate understanding why not, and at what level the state intends to perform the analyses to determine if adjustments to the rates are necessary.

   State Response (10/22/2021): Our intent would be to evaluate the need for any rate adjustments at the same level of detail on which the capitation rates are set, i.e. at the MCO, SDA and risk group level.
3. To the extent the state and actuary determine that adjustments to the MCO capitation rates are necessary as a result of the reconciliation, we would appreciate understanding if the state intends to still include a risk margin provision in the revised TIPPS amounts included in the rates based on the reconciliation. If the state intends to still include a risk margin when developing revised TIPPS amounts based on the reconciliation, we would appreciate understanding why this is reasonable.

   State Response (10/22/2021): In general, risk margins are set by program and applied uniformly across all components of the premium rate, i.e. medical, pharmacy, QIPP, CHIRP, etc…The margins are not necessarily intended to reflect the risk associated

with each individual claim type, risk group, SDA but an aggregate reflection of the risk across the entire program inclusive of all services and rate components. For this reason, we believe that a risk margin may still be necessary as this assumption is set in aggregate and not specific to the TIPPS. This assumption may need to be reevaluated given the specific circumstances in the event a rate adjustment is necessary.

7. We understand from the preprint review that the final expected provider reimbursement under this preprint is 100% of ACR for Class 1 (HRIs) and 88% of ACR for Class 2 (IMEs). Since Component 1 of TIPPS applies to provider classes 1 and 2, can the state please clarify if the state's proposed approach is expected to result in changes to the final expected provider reimbursement levels indicated in the current preprint.

   State Response: The state does not anticipate a change in the reimbursement levels indicated in the pre-print as a result of this change.

8. Require that any payments be based on performance linked to Medicaid managed care enrollees only (not Medicaid FFS), and performance-based payments must ensure that providers are achieving year over year improvement in accordance with the regulatory requirement that the arrangement must advance managed care quality goals and objectives.

State Response: The state believes the payments are based on performance linked to Medicaid managed care enrollees. HHSC has developed a hybrid model that requires providers to meet program quality requirements, but where payment is still triggered by Medicaid managed care utilization. In the TIPPS amended pre-print, both types of DPPs are selected in question 9. For example, in the TIPPS Component 3 and DPP BHS Component 2, once a provider has demonstrated achievement on their measures, they are eligible to earn payments. The payments are rate enhancements paid upon claims adjudication of certain codes identified in the program requirements. On the August 24, 2021 call with Texas, CMS indicated this was not clear in the preprint. Could we maintain the quality descriptions in our pre-print submissions, as we hope to transition toward more value-based DPPs in the future, but change the selection under question 10 to remove "Quality Payment/Pay for Performance" but leave "Medicaid-Specific Delivery System Reform" and "Performance Improvement Initiative"? Or does CMS have suggestions for other changes Texas could make to the pre-print to address this issue?

CMS Response: Based on our recent discussions with the state, CMS understands that Component 1 and 3 should be considered a fee schedule requirement (per preprint question 9b) and Component 2 should be considered a value-based payment arrangement (per preprint question 9a). If this is accurate, please update preprint question 8 (Att B) to make this distinction. Please also revise the responses to Questions 9-14 to only reflect the condition of payment for Component 2; Questions 15-18 should only reflect information for Components 1 and 3. Components 1 and 3, as they are paid per adjudicated claim, would be classified as uniform increases using an alternative fee schedule.

State Response: We will make this adjustment. However, the rate enhancement will not be using an alternative fee schedule, but rather an increase above the contracted rate. This

information has been updated in the preprint. Please see revised preprint PDF, Attachment B, Attachment C, and Attachment D.

CMS Response (9/24/2021):

9. From the revisions in the preprint, the state has indicated that all components of this payment arrangement are uniform increases where payment is conditioned upon utilization and no components are VBP (where payment is conditioned upon performance.) Can the state confirm this understanding is correct?
   State Response (9/29/2021): Yes, the state confirms CMS' understanding.

10. The state's revised preprint includes the following in response to Question 8, "Texas will discuss with CMS specifics related to Component 3 on the call scheduled for September 16, 2021." Please strike this sentence from the preprint.
    State Response (9/29/2021): The pre-print has been updated accordingly.

11. In the state's revised preprint, Question 21 no longer has a response. Please revise the preprint to include an update to Question 21.
    State Response (9/29/2021): The pre-print has been updated accordingly.

Should CMS want to restrict measurement to only Medicaid managed care members, would it be possible to transition over the first year of the program so that providers are able to make necessary system changes to stratify by Medicaid managed care only? In that instance, HHSC would need to amend the selection of measures used for tracking provider quality improvement, such as the structure measures or hospital safety measures.

12. Does CMS's concern about restricting measurement to managed care members only apply to Pay-for-performance measures in a value-based DPP? Or would it also apply to provider-reported measures used for evaluations?

CMS Response: When payment is made based upon performance, the performance must be measured to be specific to Medicaid managed care and not Medicaid FFS or another payer. We understand that providers may need more time to report the data properly to do so. When such instances have come up in other states, states will often restructure the payment from a pay-for-performance requirement to a fee schedule (e.g., uniform increase). In such instances, the uniform increase is paid per claim rather than paid based upon performance. States will often pair this change with a provider eligibility requirement that in order to obtain the uniform increase, the provider must report certain data elements according to the state's specifications. Such a strategy allows the state and providers time to report the data appropriately, collect proper baseline data and then in later years, transition to payment based upon performance in such a way that performance is measured to be specific to Medicaid managed care. Other states have used such strategies to successfully transition to VBP arrangements.

State Response: The state is amending component 2 to a uniform rate enhancement and will require provider-reported measures to be stratified by Medicaid managed care only for the purposes of the evaluation.

CMS Response (9/24/2021): The state's revised preprint indicates that component 2 payments to providers will be conditioned upon utilization rather than performance. If that is incorrect, then changes to account for this will need to be made in alignment to feedback previously provided. See comments above related to QIPP.
State Response (9/29/2021): The State confirms that CMS' understanding is correct. In Year 1, Component 2 in TIPPS will be conditioned upon utilization and a reconciliation approach identical to the reconciliation described for Component 1 will be utilized for Component 2.
CMS Response (10/18/2021): Our understanding is that the state will do a reconciliation from historical to actual utilization for Components 1 and 2, but not Component 3. Please confirm.
State Response (10/22/2021): Correct. Component 3 is already paid on actual adjudicated claims at the time of adjudication so no reconciliation for Component 3 is necessary.

The evaluation needs to be of the SDP which operates in Medicaid managed care only. For this reason, evaluation data should only include Medicaid managed care members. This would apply to both pay for performance measures and provider reported measures for evaluations.

State Response: This change to require participating providers to stratify measure reporting by Medicaid managed care will necessitate changes in the program requirements. It may also require a new program participation application and eligibility determination period or withdrawal period, as some providers will not be able to comply with this requirement in the first year of the program. Finally, these required changes will delay the provider reporting periods.

CMS Response 9/24/21: Please clarify whether the data and evaluations will be delayed due to these challenges, or that these challenges make separation of health services provided to Medicaid MCO beneficiaries and their health outcomes insurmountable.
State Response (9/29/2021): The data and evaluations may be delayed in the first year, but these challenges are not insurmountable.

With regard to year-over-year improvement, we also have additional questions:
13. HHSC assumes this applies to provider-level pay-for-performance measures in addition to evaluation measurement at the Medicaid-member level. Is that correct? **CMS Response**: Yes, the SDP should aim to have year-over-year improvement in the evaluation measures at the SDP-level (i.e., across all the providers participating in the SDP).

    For determining payment under Component 2 or any other pay for performance components, measurement should be done at the facility or provider level.

    As noted earlier, our primary concern for components of the payment arrangement where payment is conditioned upon performance, such as Component 2 in TIPPS, relates to the OIG finding on QIPP that nursing facilities that declined in performance continued to receive quality improvement incentive payments. The structure of Component 2 in TIPPS appears to raise the same sort of concerns raised about the structure of QIPP in determining payment – that there could be instances where a provider has a *significant* decline in performance but the provider would still receive a payment under Component 2 by performing at or better than the national average on at

least some of the measures. We understand that there may be natural fluctuations in provider performance; what we want to address with the state is to prevent instances when there is a notable decline in performance and yet the provider still earns payment under Component 2 because they satisfy the benchmark. We would strongly advise that the state consider adding some threshold for at least maintaining or improving performance.

As noted for QIPP, CMS believes the only way to address this concern would be that for all components where payment is conditioned upon performance on a quality measure (e.g. Component 2 of TIPPS) and the state wants to use a set benchmark that a provider must achieve to earn payment (e.g., a statewide or national benchmark), the state adopt a requirement that if the provider was already achieving the benchmark at the start of the performance measurement period, they would have to demonstrate period over period performance (e.g., year over year or quarter over quarter.) We recognize that there may be high-achieving providers that already surpassed the benchmark and show moderate fluctuations in performance that are natural fluctuations in performance. To address this, we would recommend that when measuring performance over self, the state allow for maintaining performance within the trend for the national benchmark for each measure. For example, if the national or statewide benchmark dipped by 1% from the previous period to the current period, providers who are already over the benchmark and maintained their performance measured at the individual facility level within a margin of +/-1 percent or improved by more than that would earn payment; if the same facility declined in performance by more than 1%, they would not receive payment even if their performance is over the benchmark.

State Response: As proposed, the first year of these programs (CHIRP, DPP BHS, RAPPS, and TIPPS) will establish baselines. As such, the state will not make these adjustments in administrative rule or the preprints at this time. Thank you for recognizing the option for maintenance of a high-performance rate. HHSC will consider the CMS recommendation for its second-year program designs. The requirement to demonstrate year-over-year improvement will be evident in the evaluation and structure of the second year of these programs.

CMS Response (9/24/2021): CMS' understanding is that each of the preprints listed here have moved to include only uniform increases where payment is conditioned upon utilization and not performance. If any of these proposals condition payment upon performance, then changes to account for this will need to be made in alignment to feedback previously provided. See comments above related to QIPP.

State Response (9/29/2021): The State confirms that CMS' understanding is correct. In Year 1, all components of CHIRP, TIPPS, RAPPS, and DPP for BHS will be uniform increases where payment is conditioned upon utilization and not performance. In QIPP, Components 2, 3, and 4 will remain value based payments conditioning payment upon performance.

14. How should this apply to structure measures currently included in the program? **CMS Response**: As noted earlier, CMS strongly encourages states to use outcome measures for

value-based payments. Using structural measures does not necessarily lead to health improvements for Medicaid beneficiaries. Using structure or count measures along with outcome measures can, however, show the importance of ensuring adequate staffing on health outcomes of beneficiaries, especially when done over time. We encourage Texas, therefore, to use these measures along with outcome measures that are measuring the impact of the healthcare. Also process measures, such as vaccine administration, can be used with outcome measures.

If the state chooses to pair outcome measures with structure measures and/or process measures, the same advice would apply as in response to part b above.
State Response: The state has included structure, process and outcome measures in TIPPS. We will continue to do so, as the structures are encouraging DSRIP-informed best practices that impact improvement in health outcomes. It is our understanding that CMS does not require year-over-year improvement in structure measures and prefers process and outcome measures for the pay-for-performance components of these programs.

CMS Response (9/24/2021): Thank you for the state's response. CMS' understanding is the state has revised this preprint so that the payments under this payment arrangement are no longer conditioned upon performance. CMS' understanding is the inclusion of structure, process and outcomes measures for TIPPS refers to the evaluation of the payment arrangement and/or provider eligibility for the class. If this is incorrect and any component of TIPPS requires payments conditioned upon performance, the guidance provided earlier for QIPP Components 2-4 would apply.
State Response (9/29/2021): Noted. The State confirms that CMS' understanding is correct and in Year 1 TIPPS will not include any payments conditioned upon performance.

Texas DPPs feature measures intended exclusively as improvement over self (IOS) measures or benchmark measures. If a measure is exclusively a benchmark measure, is it acceptable for a provider to maintain performance above the benchmark? **CMS Response**: As noted earlier, our primary concern for components of the payment arrangement where payment is conditioned upon performance, such as Component 2 in TIPPS, relates to the OIG finding on QIPP that nursing facilities that declined in performance continued to receive quality improvement incentive payments. The structure of Component 2 in TIPPS appears to raise the same sort of concerns raised about the structure of QIPP in determining payment – that there could be instances where a provider has a *significant* decline in performance but the provider would still receive a payment under Component 2 by performing at or better than the national average on at least some of the measures. We understand that there may be natural fluctuations in provider performance; what we want to address with the state is to prevent instances when there is a notable decline in performance and yet the provider still earns payment under Component 2 because they satisfy the benchmark. We would strongly advise that the state consider adding some threshold for at least maintaining or improving performance.

As noted for QIPP, CMS believes the only way to address this concern would be that for all components where payment is conditioned upon performance on a quality measure (e.g. Component 2 of TIPPS) and the state wants to use a set benchmark that a provider must achieve to earn payment (e.g. a statewide or national benchmark), the state adopt a requirement that if the provider was already achieving the benchmark at the start of the performance measurement period, they would have to demonstrate period over period performance (e.g. year over year or quarter over quarter.)
State Response: The state will assess using IOS goals for providers who are performing above the benchmark goal. For CHIRP, DPP BHS, RAPPS, and TIPPS, the requirement to demonstrate year-over-year improvement is something that will be evident in the evaluation and structure of the second year of these programs. As proposed, the first year of these programs will establish baselines.

CMS Response (9/24/2021): Thank you for the state's response. CMS' understanding is the state has revised this preprint so that the payments under this payment arrangement are no longer conditioned upon performance. CMS' understanding is the inclusion of structure, process and outcomes measures for TIPPS refers to the evaluation of the payment arrangement and/or provider eligibility for the class. If this is incorrect and any component of TIPPS requires payments conditioned upon performance, the guidance provided earlier for QIPP Components 2-4 would apply.
State Response (9/29/2021): Noted. The State confirms that CMS' understanding is correct, and in Year 1 TIPPS will not include any payments conditioned upon performance.

15. Would maintenance of a rate of performance for a high performer be acceptable? **CMS Response:** We recognize that there may be high-achieving providers that already surpassed the benchmark and show moderate fluctuations in performance that are natural fluctuations in performance. To address this, we would recommend that when measuring performance over self, the state allow for maintaining performance within the trend for the national benchmark for each measure. For example, if the national or statewide benchmark dipped by 1% from the previous period to the current period, providers who are already over the benchmark and maintained their performance measured at the individual facility level within a margin of +/-1 percent or improved by more than that would earn payment; if the same facility declined in performance by more than 1%, they would not receive payment even if their performance is over the benchmark.
State Response: As proposed, the first year of these programs (CHIRP, DPP BHS, RAPPS, and TIPPS) will establish baselines. As such, the state will not make these adjustments in administrative rule or the preprints at this time. Thank you for recognizing the option for maintenance of a high-performance rate. HHSC will consider the CMS recommendation for its second-year program designs. The requirement to demonstrate year-over-year improvement will be evident in the evaluation and structure of the second year of these programs.

CMS Response (9/24/2021): Thank you for the state's response. CMS' understanding is the state has revised this preprint so that the payments under this payment arrangement are no longer conditioned upon performance. CMS' understanding is the inclusion of structure, process and outcomes measures for TIPPS refers to the evaluation of the payment

arrangement and/or provider eligibility for the class. If this is incorrect and any component of TIPPS requires payments conditioned upon performance, the guidance provided earlier for QIPP Components 2-4 would apply.

State Response (9/29/2021): Noted. The State confirms that CMS' understanding is correct, and in Year 1 TIPPS will not include any payments conditioned upon performance.

16. Refine the evaluation plan for TIPPS to ensure that the effect of the TIPPS state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.

State Response: The state is working with our EQRO contractor to refine an attribution methodology for each program. There are some measures included in the evaluation which cannot be limited to providers participating in the DPP. Some of the measures that cannot be attributed exclusively to one DPP provider are CMS core set measures recommended by CMS for DPP evaluations. In light of the call with Texas on August 24 and CMS' acknowledgement, we will proceed with maintaining the CMS core set measures selected for the respective evaluations, even though they cannot be attributed only to providers participating in the corresponding DPPs. HHSC is also open to providing one annual DPP evaluation which breaks out DPP-specific attribution measures, as suggested by CMS in the August 24, 2021 call with Texas.

17. Does CMS have any other recommendations for how to isolate the impact of the DPP other than the work HHSC is undertaking with its contractor to do so? **CMS Response**: Please refer to the overarching comments at the top of this paper.

State Response: Please refer to our responses to CMS's overarching comments.

With respect to baseline year, in a phone call on January 27, 2021 with CMS, HHSC proposed using CY 2020 and CY2021 as baselines because of the timing of the beginning of the program (CY 2021 would include 4 months of the start of the program) and the impact of COVID. Using the two years was intended to capture that context for future measurement. CMS indicated the proposal made sense. If CMS prefers that we use only one year, HHSC could use CY 2021 for the new TIPPS evaluation measures. However, this would delay further any evaluation of the programs because of data lags (please see page 5 of the TIPPS updated evaluation plan for timeline of available data).

With respect to year-over-year improvement, it is the state's goal to have improvement year-over-year, but we are also cognizant of not being able to set goals at this point because of the unknown impact of the PHE.

18. Does CMS have a recommendation for how the state can address this issue in the evaluation plan? **CMS Response**: CMS recognizes all healthcare systems have been impacted by COVID and that year-over-year improvement will be challenged by the PHE. We take that into consideration in our review of quality improvement efforts. We anticipate that the PHE will be part of the narrative and outcomes of the SDP evaluations including how COVID impacted the evaluation findings.

State Response: We will include this in the evaluation discussion. Does CMS have concerns with the goals and targets we have included in the plans?

CMS Response 9/24/21: Our concern is that the state has not identified any overall quality improvement targets for the SDPs. The state will need to provide those overall quality improvement targets (for each measure) for SFY 2023; that timeframe allows the state to see 2021 data and adjust for COVID.

State Response (9/29/2021): As acknowledged by CMS, the SFY2022 preprints will not include improvement targets as baseline data is pending. The State will include initial improvement targets for achievement in CY2022 in the SFY2023/Year 2 preprint submissions. However, the State may submit an addendum to update these improvement targets during SFY2023 after CY2021 data are available (estimated in summer/fall 2022).

19. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable? **CMS Response:** We recognize that there may be high-achieving providers that already surpassed the benchmark and show moderate fluctuations in performance that are natural fluctuations in performance. To address this, we would recommend that when measuring performance over self, the state allow for maintaining performance within the trend for the national benchmark for each measure. For example, if the national or statewide benchmark dipped by 1% from the previous period to the current period, providers who are already over the benchmark and maintained their performance measured at the individual facility level within a margin of +/-1 percent or improved by more than that would earn payment; if the same facility declined in performance by more than 1%, they would not receive payment even if their performance is over the benchmark.

    State Response: As proposed, the first year of these programs (CHIRP, DPP BHS, RAPPS, and TIPPS) will establish baselines. As such, the state will not make these adjustments in administrative rule or the preprints at this time. Thank you for recognizing the option for maintenance of a high-performance rate. HHSC will consider the CMS recommendation for its second-year program designs. The requirement to demonstrate year-over-year improvement will be evident in the evaluation and structure of the second year of these programs.

CMS Response (9/24/2021): CMS' understanding is that each of the preprints listed here have moved to include only uniform increases where payment is conditioned upon utilization and not performance. If any of these proposals condition payment upon performance, then changes to account for this will need to be made in alignment to feedback previously provided. See comments above related to QIPP.

State Response (9/29/2021): The State confirms that CMS' understanding is correct. In Year 1 all components of CHIRP, TIPPS, RAPPS, and DPP for BHS will be uniform increases where payment is conditioned upon utilization and not performance. In QIPP, Components 2, 3, and 4 will remain value based payments conditioning payment upon performance.

Rural Access to Primary and Preventative Services (RAPPS)	1. Remove the 10% reconciliation threshold and base payments only on current utilization or performance measured during the rating period (rather than historical utilization or performance). **State Response:** We understand from the call between Texas and CMS on August 20, 2021, CMS will not consider Texas's proposal of a reduced threshold for SFY 2022, with a complete elimination of the structure for SFY2023. In an effort to achieve a pathway forward for this important program, Texas would like to utilize a payment structure where interim payments for SFY 2022 are based initially upon the historical utilization data, with final payments made based upon actual data at the end of the program year, with no contingency for a variation in utilization data. This approach will allow for consistent payments to be made through the program year, but final payments to be based exclusively on actual utilization. Would CMS agree that this approach resolves any outstanding concerns about the tie to utilization? If so, Texas will submit a revised pre-print to this effect immediately. **CMS Response**: What the state has described for SFY 2022 for RAPPS Component 1, where interim payments would initially be based upon historical information but reconciled to actual utilization during the rating period, would be permissible. We do have a few follow-up questions to ensure our understanding of this arrangement: State Response: Thank you for this feedback; we are glad that this matter can be considered resolved for the purposes of consideration of our pending SDP approvals. **CMS Response (10/18/2021):** Our understanding is that only RAPPS Component 1, not Component 2, will have a reconciliation from historical to actual utilization. However, in Attachment B for preprint question 8, it indicates for Component 2 that "A separate reconciliation will be performed for rural health clinics based on actual utilization." Can the state please clarify? **State Response (10/22/2021)**: The statement that CMS refers to is not in the context of Component 2, but is a reiteration indiciating that the reconciliation will be performed for Component 1, which was described in more detail under the paragraph specific to Component 1 in Attachment B. 2. Please confirm our understanding that proposed approach of continuing interim payments based on past utilization with a final year-end payment based on actual utilization only applies to Component 1 of the directed payment. State Response: Texas confirms CMS' understanding. 3. Please describe in more detail how the payments will be made under the state's new proposal to replace the reconciliation threshold. Please provide a step-by step breakdown for how payment will work for both the MCOs and providers -- including whether the interim payments will be based on the same monthly payment amount proposed in the current preprint, when interim payments will be made based on historical utilization, how long such interim payments will continue to be made based on historical utilization, when the payments will be made based on actual utilization, and how the initial payments made based on historical utilization will be reconciled to actual utilization during the rating period. Please also discuss if the reconciliation could potentially result in recoupments from MCOs or providers.

State Response: Please see Attachment A for a timeline and high-level description of the process. There will be three subprocesses required as part of this overall process. In the first subprocess, HHSC will pay MCOs a monthly actuarially sound capitated rate based upon actual caseloads each month. MCOs will adjudicate actual claims through normal processes and then submit to HHSC encounter data. Typically, due to claims processing timelines, encounter data for a rating period is usually considered substantially complete approximately 120 days after the end of the rating period, which for Texas means December 31, 2022 for the September 1, 2021 through August 31, 2022 rating period. In a separate subprocess, HHSC receives quality-related data from providers that is required as a condition of participation in the program. HHSC will direct MCOs to issue payments to providers based upon historical data and using funds received by the MCO in the monthly capitated rate that was paid. The MCO will issue the interim payment to the provider monthly. In the final subprocess, approximately 120 days after the end of the rating period, HHSC will reconcile the historical utilization that was used as the basis of the interim payments to the actual encounters reported by the MCOs. HHSC will then direct the MCOs to recoup from and redistribute funds to providers based upon the reconciled information. The MCOs will not experience recoupments as the capitated rates paid to the MCOs will include all necessary payments. Providers may experience recoupments or receive additional funds based upon historical-to-actual utilization fluctuations.

CMS Response (9/24/2021): CMS appreciates the additional information provided on the process. CMS would like to confirm the following:

State Response (9/29/2021): HHSC is happy to share additional information to confirm CMS' understanding of the reconciliation process. Per CMS' September 10, 2021 statement that the reconciliation process would be permissible under the regulation, we are glad that this matter can be considered resolved for the purposes of consideration of our pending SDP approvals.

1. The 3 processes indicate that no changes will be made to the payments the MCO receives from the state; changes to the payments would occur for the providers within what the state has paid the plans, is that correct?

   State Response (9/29/2021): Yes, that is the intent. However, there may be modifications to MCO payments if the redistributions are significant to a point that the resulting adjustments would no longer be considered actuarially sound.

2. Does the state anticipate any amendments to the rates or rate certifications to account for the reconciliation requirement?

   State Response (9/29/2021): Not at this time.

3. How will the state inform the plans of any needed recoupments or redistributions of the funds to providers? Through updates to the contract?

   State Response (9/29/2021): The state will inform the MCOs via an updated payment scorecard that will show any provider level payment adjustments (positive or negative) that are required.

   CMS Response (10/18/2021): We understand that the payment scorecard has historically been used for payments to QIPP providers, and that the state will now include direction in

the MCO contracts for using this scorecard for when recoupments or redistributions are needed for providers participating in TIPPS, BHS and RAPPS. Is this correct?

State Response (10/22/2021): The state will create a scorecard specific to each program that is similar to the scorecard used in QIPP, but there will not be a consolidated scorecard for all programs. The program-specific scorecards will be used to indicate when recoupments or redistributions are necessary.

4. CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.

   State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

5. The response to Question 9a in the preprint indicates that the payment for Component 1 will be a uniform increase of $22.53 for free-standing RHCs and $20.74 for hospital-based RHCs. Can the state confirm this is correct? Are the payments made under Component 1 to provider on a PMPM basis or on a per service (or per claim) basis? Would the amount paid for each class change with the reconciliation?

   State Response (9/29/2021): Yes, we confirm these amounts are correct. The impact of the payment increase is a uniform increase based upon utilization; however, the state intends on making the payments as a lump sum monthly payment during the program year, prior to the reconciliation to actual RHC claims at the end of the program period. The amounts could change as the state intends to maintain the size of component 1 as identified in the pre-print but would adjust the amount if the actual utilization varies from the historical. The adjustment would take place at the time of the reconciliation.

   CMS Response (10/18/2021): The state says, "The amounts could change as the state intends to maintain the size of component 1 as identified in the pre-print but would adjust the amount if the actual utilization varies from the historical. The adjustment would take place at the time of the reconciliation."

   e. We understand from this response that the uniform increase amounts may change to ensure that the state maintains the size of components 1. Is that correct?

      State Response (10/22/2021): No, if the actual program size fluctuates as a result of caseload, the size of Component 1 would fluctuate proportionately as Component 1 is designed to be equal to a percentage of the overall program value. The reconciliation performed at the end of the program year will be

performed to reconcile to the actual value of Component 1 based upon the actual value of the overall program as paid through the program year.

f. Our understanding from previous rounds of review is that the targeted amount for Component 1 is $7,957,751. Can the state please confirm this is the amount that the state intends to reconcile to? Will this targeted amount include any provisions for administration, risk margin, and premium tax?

State Response (10/22/2021): The amount identified for Component 1 is an estimate based upon the proposed program size. However, if the actual program size fluctuates as a result of caseload, the size of Component 1 would fluctuate proportionately as Component 1 is designed to be equal to a percentage of the overall program value. The reconciliation performed at the end of the program year will be performed to reconcile to the actual value of Component 1 based upon the actual value of the overall program as paid through the program year. All managed care capitated payments will include administration, risk margin, and premium tax, as appropriate. The Component 1 value above does not include any provisions associated with administration, risk margin, and premium tax as these are removed from the total program funds before Component 1's value is calculated.

6. The state indicated on calls that the state intended to continue incorporating this payment arrangement as an adjustment to base rates rather than a separate payment term. Given the revised reconciliation process for Component 1, can the state affirm that it still plans to incorporate all components of this payment arrangement through an adjustment to base rates or would the state pay any part of this payment arrangement, such as Component 1, as a separate payment term?

State Response (9/29/2021): Yes, all components will be through an adjustment to base rates.

CMS Response (10/18/2021): The state indicates in the response to question 5 above that the uniform percentage increase currently documented in the preprint would change at the time of the reconciliation as the state intends to maintain the size of Component 1 funding currently identified in the preprint. Is the state's goal under Component 1 or any other Component to ensure that exactly a certain amount (e.g., $7,957,751) is expended by the plans for payments to providers under any specific components (e.g., Component 1)? Or are the amounts listed for each component an estimate that is subject to change? If so, what would cause it to change?

State Response (10/22/2021): To clarify, the state intends to maintain the size of Component 1 as a percentage of the overall program value; however, the gross value of Component 1 may change if the overall program value fluctuates from the estimated value. This fluctuation would be a result of changes in caseload from the forecasted caseload for the fiscal year. However, the payments will still be reconciled against actual utilization, so the actual percentage of program value compared to actual utilization may result in a different percentage rate increase than the estimated rate increase, which is based upon historical utilization and estimated program values.

CMS Response (10/18/2021): Does the state direct the plans to set aside any portion of the capitation rate paid to them for this payment arrangement?

State Response (10/22/2021): No. The portion of the capitation rate attributed to each DPP has been separately identified and reported to the MCOs but no direction has been provided on how the MCOs should "set aside" these funds.

CMS Response (10/18/2021): Are the plans directed to use a specific portion of the capitation rates paid to them to pay out Component 1?
State Response (10/22/2021): No. The capitation rates have been calculated separately for each DPP; however, this add-on rate isn't delineated between the various components.

7. Please also revise the preprint to include the information on the reconciliation process described in Attachment A.
State Response (9/29/2021): Please see the changes in the attached pre-prints, per your request.

4. Can the state confirm that all payments (including the interim payments based on historical data) will be reconciled to actual utilization data during the rating period? Or will those initial interim payments remain based only on historical utilization?
State Response: All payments will be reconciled to actual utilization data during the final reconciliation.

CMS Response (9/24/2021): See CMS Round 3 responses, Question 4 above - CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.
State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

5. We will note that states that make interim payments based on historical utilization and then reconcile to actual data have noted that reconciliations like this can be administratively burdensome.
State Response: Noted. The importance of the program to our healthcare safety net is significant so HHSC will absorb the administrative burden.

CMS Response (9/24/2021): See CMS Round 3 responses, Question 4 above - CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its

preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.

State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

6. CMS' understanding from previous responses is that the reconciliation threshold is a part of the state's administrative code. Can the state confirm that this change can be implemented without changes to the administrative code? If not, can the state describe the process and timing for making such changes? If changes to the administrative code are needed, will the state be able to implement those retroactively back to the start of the rating period?

   State Response: Implementing this change will require the state to modify the Texas Administrative Code. HHSC will propose that rule changes will apply to the entire program period, though the effective date of the rule change will be subsequent to the start of the rating period.

CMS Response (9/24/2021): Can the state elaborate the timeframes that would be needed to complete the state rulemaking process? Can the state also comment on if they anticipate challenges to the rulemaking and what impact those would have on implementation timelines?

State Response (9/29/2021): The Texas rulemaking process requires filing of a proposed rule with the Texas Register by Monday at noon to have the proposal published 11 days later (the second Friday after submission). Proposed rules are generally posted for a 30-day public comment period. Following the public comment period, the rule can be adopted with or without changes. Typically, a rule takes effect 20 days after the date the rule is filed with the Texas Register. This total process requires a minimum of 51 days; however, accounting for time necessary to prepare the rules for publication, to review public comments, and make any changes as a result thereof, HHSC typically assumes a minimum of 90 days will be necessary. HHSC anticipates receiving public comments but also anticipates that providers prefer changes if they are necessary for CMS approval for state fiscal year 2022.

For more information, CMS may wish to visit our webpage on rulemaking: https://www.hhs.texas.gov/laws-regulations/policies-rules/health-human-services-rulemaking.

CMS Response (10/18/2021): From the description above, it sounds like CMS would not expect rate amendments or contract amendments to implement the proposed changes until 90 days after the start of rulemaking at the state level. Is this correct?

State Response (10/22/2021): With respect to rule making changes described above, the state does not anticipate that rate changes or contract amendments would be required to implement the changes proposed for RAPPS, so the rates and contracts already filed with CMS will stand.

7. Can the state please describe how this new approach will be accounted for in the capitation rates? Will the directed payment be incorporated into the rates as a separate payment term? It would be helpful for the state to clarify how this new approach would impact the amounts included in the initial certification, and if the state and actuary intend to amend the rates in the future once the final payments based on actual utilization are known.

   State Response: We expect that the RAPPS would continue to be incorporated as an adjustment to the base capitation rates and included in the monthly premium. Once final data is available at the end of the year, a retroactive adjustment to the RAPPS capitation rates may be necessary, in which case HHSC would amend the MCO contracts and submit an actuarial rate amendment.

CMS Response (9/24/2021): See CMS Round 3 responses, Questions 1, 2 and 6. Appendix A, process 3 does not indicate that there will be any changes to the MCO payments and the state's response above states, "The MCOs will not experience recoupments as the capitated rates paid to the MCOs will include all necessary payments." However, this response indicates that retroactive adjustments to the capitation rates may be necessary. Can the state please clarify if the state expects or anticipates an amendment to the rates and rate certifications may be needed and under what circumstances?

State Response (9/29/2021): The state does not anticipate making any prospective capitated rate changes based upon this modification. However, once final data is available at the end of the year, a retroactive adjustment to the capitation rates may be necessary if the degree of recoupments and redistributions is significant to the point that the capitated rates are no longer actuarially sound. If that occurs, HHSC would amend the MCO contracts and submit an actuarial rate amendment.

CMS Response (10/18/2021): The state indicates that there may be modifications to MCO payments if the redistributions are significant to a point that the resulting adjustments would no longer be considered actuarially sound. We would appreciate better understanding under what circumstances the MCO rates would be revised.

1. Can the state and its actuary please discuss how you are defining "significant" in this instance, and what threshold would trigger adjustments to the MCO capitation rates. Please address both the potential instances when MCOs are required to pay out more RAPPS payments than the amount of funding included prospectively in capitation rates, and when MCOs are required to pay out less RAPPS payments than the amount of funding included prospectively in the capitation rates.

   State Response (10/22/2021): The intent of any reconciliation would be to ensure that all MCO capitation rates continued to be considered actuarially sound and to ensure that no MCO was inadvertently harmed (or profited) due to shifts in utilization and provider payments that are beyond their control. The threshold for triggering a retroactive rate change is difficult to define in advance given that there are numerous variables that impact the capitation rates and would need to be taken into consideration. Without being overly prescriptive we believe that the risk margin

would be the starting point for evaluating whether a modification would be necessary and that such consideration would be equivalent for the cases of both over and underpayment. There could be scenarios where the trigger could be higher or lower than the risk margin such as large scale utilization shifts that impact the overall profitability of the MCOs either positively or negatively resulting in variations in other assumptions that offset the need to adjust rates retroactively.

2. Since CMS evaluates actuarial soundness at a rate cell level, we would appreciate understanding if the state and actuary intend to review whether adjustments to the rates are necessary as a result of the reconciliation at a rate cell level. If not, we would appreciate understanding why not, and at what level the state intends to perform the analyses to determine if adjustments to the rates are necessary.

   State Response (10/22/2021): Our intent would be to evaluate the need for any rate adjustments at the same level of detail on which the capitation rates are set, i.e. at the MCO, SDA and risk group level.

3. To the extent the state and actuary determine that adjustments to the MCO capitation rates are necessary as a result of the reconciliation, we would appreciate understanding if the state intends to still include a risk margin provision in the revised RAPPS amounts included in the rates based on the reconciliation. If the state intends to still include a risk margin when developing revised RAPPS amounts based on the reconciliation, we would appreciate understanding why this is reasonable.

   State Response (10/22/2021): In general, risk margins are set by program and applied uniformly across all components of the premium rate, i.e. medical, pharmacy, QIPP, CHIRP, etc…The margins are not necessarily intended to reflect the risk associated with each individual claim type, risk group, SDA but an aggregate reflection of the risk across the entire program inclusive of all services and rate components. For this reason, we believe that a risk margin may still be necessary as this assumption is set in aggregate and not specific to the RAPPS. This assumption may need to be reevaluated given the specific circumstances in the event a rate adjustment is necessary.

8. We wanted to note that during Round 2 of preprint review, the state revised the uniform percent increase for Component 2, but did not provide a revised total dollar amount for the directed payment. Can the state please provide the final total dollar amount for this directed payment, inclusive of the new reconciliation approach? We note that the total amount of funding for RAPPS included in the current SFY 2022 certifications appears to be $11,128,433.

   State Response: The final total dollar amount for RAPPS is $11,264,178. See the breakout below:

   i. Component 1: $7,959,071
   ii. Component 2: $2,653,024
   iii. Administration, risk margin, or premium tax: $652,084

   This is based on an updated rate increase for Component 2 of 3.77%, rounded to the nearest hundredth for MCO implementation. This information is also provided in an updated preprint.

CMS Response (9/24/2021): Can the state confirm that the provider payment level analysis provided in the preprint reflects these changes? If not, please provide an updated preprint with an updated provider payment level analysis that reflects these changes.
State Response (9/29/2021): Yes, the state confirms that Question 23 (table 2) reflects these updates.

9. Refine the evaluation plan for RAPPS to ensure that the effect of the RAPPS state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.

State Response: The state is working with our EQRO contractor to refine an attribution methodology for each program. There are some measures included in the evaluation which cannot be limited to providers participating in the DPP. Some of the measures that cannot be attributed exclusively to one DPP provider are CMS core set measures recommended by CMS for DPP evaluations. In light of the call with Texas on August 24 and CMS' acknowledgement, we will proceed with maintaining the CMS core set measures selected for the respective evaluations, even though they cannot be attributed only to providers participating in the corresponding DPPs.
HHSC is also open to providing one annual DPP evaluation which breaks out DPP-specific attribution measures, as suggested by CMS in the August 24, 2021 call with Texas.

10. Does CMS have any other recommendations for how to isolate the impact of the DPP other than the work HHSC is undertaking with its contractor to do so? **CMS Response:** Please refer to the overarching comments at the top of this paper.
    State Response: Please refer to our responses to CMS's overarching comments.

With respect to baseline year, in a phone call on January 27, 2021 with CMS, HHSC proposed using CY 2020 and CY2021 as baselines because of the timing of the beginning of the program (CY 2021 would include 4 months of the start of the program) and the impact of COVID. Using the two years was intended to capture that context for future measurement. CMS indicated the proposal made sense. If CMS prefers that we use only one year, HHSC could use CY 2021 for the new RAPPS evaluation measures. However, this would delay further any evaluation of the programs because of data lags (please see page 5 of the RAPPS updated evaluation plan for timeline of available data).

With respect to year-over-year improvement, it is the state's goal to have improvement year-over-year, but we are also cognizant of not being able to set goals at this point because of the unknown impact of the PHE.

11. Does CMS have a recommendation for how the state can address this issue in the evaluation plan? **CMS Response**: CMS recognizes all healthcare systems have been impacted by COVID and that year-over-year improvement will be challenged by the PHE. We take that into consideration in our review of quality improvement efforts. We anticipate that the PHE will be part of the narrative and outcomes of the SDP evaluations including how COVID impacted the evaluation findings.

	State Response: We will include this in the evaluation discussion. Does CMS have concerns with the goals and targets we have included in the plans? **CMS Response 9/24/21**: Our concern is that the state has not identified any overall quality improvement targets for the SDPs. The state will need to provide those overall quality improvement targets (for each measure) for SFY 2023; that timeframe allows the state to see 2021 data and adjust for COVID. **State Response (9/29/2021):** As acknowledged by CMS, the SFY2022 preprints will not include improvement targets as baseline data is pending. The State will include initial improvement targets for achievement in CY2022 in the SFY2023/Year 2 preprint submissions. However, the State may submit an addendum to update these improvement targets during SFY2023 after CY2021 data are available (estimated in summer/fall 2022). 12. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable? **CMS Response:** We recognize that there may be high-achieving providers that already surpassed the benchmark and show moderate fluctuations in performance that are natural fluctuations in performance. To address this, we would recommend that when measuring performance over self, the state allow for maintaining performance within the trend for the national benchmark for each measure. For example, if the national or statewide benchmark dipped by 1% from the previous period to the current period, providers who are already over the benchmark and maintained their performance measured at the individual facility level within a margin of +/-1 percent or improved by more than that would earn payment; if the same facility declined in performance by more than 1%, they would not receive payment even if their performance is over the benchmark. State Response: As proposed, the first year of these programs (CHIRP, DPP BHS, RAPPS, and TIPPS) will establish baselines. As such, the state will not make these adjustments in administrative rule or the preprints at this time. Thank you for recognizing the option for maintenance of a high-performance rate. HHSC will consider the CMS recommendation for its second-year program designs. The requirement to demonstrate year-over-year improvement will be evident in the evaluation and structure of the second year of these programs.
Behavioral Health Services Directed Payment Program (BHS)	1. Remove the 10% reconciliation threshold and base payments only on current utilization or performance measured during the rating period (rather than historical utilization or performance). **State Response:** We understand from the call between Texas and CMS on August 20, 2021, CMS will not consider Texas's proposal of a reduced threshold for SFY 2022, with a complete elimination of the structure for SFY2023. In an effort to achieve a pathway forward for this important program, Texas would like to utilize a payment structure where interim payments for SFY 2022 are based initially upon the historical utilization data, with final payments made based upon actual data at the end of the program year, with no contingency for a variation in utilization data. This approach will allow for consistent payments to be made through the program year, but final payments to be based exclusively on actual utilization. Would CMS agree that this approach resolves any outstanding concerns about the tie to utilization? If so, Texas will submit a revised pre-print to this effect immediately.

CMS Response: What the state has described for SFY 2022 for BHS Component 1, where interim payments would initially be based upon historical information but reconciled to actual utilization during the rating period, would be permissible. We do have a few follow-up questions to ensure our understanding of this arrangement:
State Response: Thank you for this feedback; we are glad that this matter can be considered resolved for the purposes of consideration of our pending SDP approvals.

1. Please confirm our understanding that proposed approach of continuing interim payments based on past utilization with a final year-end payment based on actual utilization only applies to Component 1 of the directed payment.
   State Response: Texas confirms CMS' understanding.
2. Please describe in more detail how the payments will be made under the state's new proposal to replace the reconciliation threshold. Please provide a step-by step breakdown for how payment will work for both the MCOs and providers -- including whether the interim payments will be based on the same monthly payment amount proposed in the current preprint, when interim payments will be made based on historical utilization, how long such interim payments will continue to be made based on historical utilization, when the payments will be made based on actual utilization, and how the initial payments made based on historical utilization will be reconciled to actual utilization during the rating period. Please also discuss if the reconciliation could potentially result in recoupments from MCOs or providers.
   State Response: Please see Attachment A for a timeline and high-level description of the process. There will be three subprocesses required as part of this overall process. In the first subprocess, HHSC will pay MCOs a monthly actuarially sound capitated rate based upon actual caseloads each month. MCOs will adjudicate actual claims through normal processes and then submit to HHSC encounter data. Typically, due to claims processing timelines, encounter data for a rating period is usually considered substantially complete approximately 120 days after the end of the rating period, which for Texas means December 31, 2022 for the September 1, 2021 through August 31, 2022 rating period. In a separate subprocess, HHSC receives quality-related data from providers that is required as a condition of participation in the program. HHSC will direct MCOs to issue payments to providers based upon historical data and using funds received by the MCO in the monthly capitated rate that was paid. The MCO will issue the interim payment to the provider monthly. In the final subprocess, approximately 120 days after the end of the rating period, HHSC will reconcile the historical utilization that was used as the basis of the interim payments to the actual encounters reported by the MCOs. HHSC will then direct the MCOs to recoup from and redistribute funds to providers based upon the reconciled information. The MCOs will not experience recoupments as the capitated rates paid to the MCOs will include all necessary payments. Providers may experience recoupments or receive additional funds based upon historical-to-actual utilization fluctuations.

CMS Response (9/24/2021): CMS appreciates the additional information provided on the process. CMS would like to confirm the following:

	State Response (9/29/2021): HHSC is happy to share additional information to confirm CMS' understanding of the reconciliation process. Per CMS' September 10, 2021 statement that the reconciliation process would be permissible under the regulation, we are glad that this matter can be considered resolved for the purposes of consideration of our pending SDP approvals. 1. The 3 processes indicate that no changes will be made to the payments the MCO receives from the state; changes to the payments would occur for the providers within what the state has paid the plans, is that correct? **State Response (9/29/2021)**: Yes, that is the intent. However, there may be modifications to MCO payments if the redistributions are significant to a point that the resulting adjustments would no longer be considered actuarially sound. 2. Does the state anticipate any amendments to the rates or rate certifications to account for the reconciliation requirement? **State Response (9/29/2021)**: Not at this time. 3. How will the state inform the plans of any needed recoupments or redistributions of the funds to providers? Through updates to the contract? **State Response (9/29/2021)**: The state will inform the MCOs via an updated payment scorecard that will show any provider level payment adjustments (positive or negative) that are required. **CMS Response (10/18/2021):** We understand that the payment scorecard has historically been used for payments to QIPP providers, and that the state will now include direction in the MCO contracts for using this scorecard for when recoupments or redistributions are needed for providers participating in TIPPS, BHS and RAPPS. Is this correct? **State Response (10/22/2021)**: The state will create a scorecard specific to each program that is similar to the scorecard used in QIPP, but there will not be a consolidated scorecard for all programs. The program-specific scorecards will be used to indicate when recoupments or redistributions are necessary. 4. CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A. **State Response (9/29/2021)**: The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

5. The response to Question 9a in the preprint indicates that the payment for Component 1 will be a uniform increase of $23.77. Can the state confirm this is correct? Are the payments made under Component 1 to provider on a PMPM basis or on a per service (or per claim) basis? Would the amount paid under this component change with the reconciliation?

State Response (9/29/2021): Yes, we confirm the amount is correct. The impact of the payment increase is uniform increase based upon historical utilization; however, the state intends on making the payments as a lump sum monthly payment during the program year, prior to the reconciliation to actual CMHC claims at the end of the program period. The amount could change as the state intends to maintain the size of component 1 as identified in the pre-print but would adjust the percentage per claim if the actual utilization varies from the historical. The adjustment would take place at the time of the reconciliation.

CMS Response (10/18/2021): The state says, "The amounts could change as the state intends to maintain the size of component 1 as identified in the pre-print but would adjust the amount if the actual utilization varies from the historical. The adjustment would take place at the time of the reconciliation."

a. We understand from this response that the uniform dollar increase amount may change (and state cites adjusting the percentage per claim in the response but we believe the state meant to stay adjusting the dollar increase per claim) to ensure that the state maintains the size of component 1. Is that correct?

State Response (10/22/2021): No, if the actual program size fluctuates as a result of caseload, the size of Component 1 would fluctuate proportionately as Component 1 is designed to be equal to a percentage of the overall program value. The reconciliation performed at the end of the program year will be performed to reconcile to the actual value of Component 1 based upon the actual value of the overall program as paid through the program year.

b. The state informed us below that the total dollar estimate is $108,324,269 for Component 1. Can the state confirm that this is the targeted amount for Component 1 funding that they intend to reconcile to? Will this targeted amount include any provisions for administration, risk margin and premium tax?

State Response (10/22/2021): The amount identified for Component 1 is an estimate based upon the proposed program size. However, if the actual program size fluctuates as a result of caseload, the size of Component 1 would fluctuate proportionately as Component 1 is designed to be equal to a percentage of the overall program value. The reconciliation performed at the end of the program year will be performed to reconcile to the actual value of Component 1 based upon the actual value of the overall program as paid through the program year. All managed care capitated payments will include administration, risk margin, and premium tax, as appropriate. The Component 1 value listed above does not include any provisions associated with administration, risk margin, and premium tax.

6. The state indicated on calls that the state intended to continue incorporating this payment arrangement as an adjustment to base rates rather than a separate payment term. Given the revised reconciliation process for Component 1, can the state affirm that it still plans to

incorporate all components of this payment arrangement through an adjustment to base rates or would the state pay any part of this payment arrangement, such as Component 1, as a separate payment term?

State Response (9/29/2021): Yes, all components will be through an adjustment to base rates.

CMS Response (10/18/2021): The state indicates in the response to question 5 above that the uniform percentage increase currently documented in the preprint would change at the time of the reconciliation as the state intends to maintain the size of Component 1 funding currently identified in the preprint. Is the state's goal under Component 1 or any other Component to ensure that exactly a certain amount (e.g., $108,324,269) is expended by the plans for payments to providers under any specific components (e.g., Component 1)? Or are the amounts listed for each component an estimate that is subject to change? If so, what would cause it to change?

State Response (10/22/2021): To clarify, the state intends to maintain the size of Component 1 as a percentage of the overall program value; however, the gross value of Component 1 may change if the overall program value fluctuates from the estimated value. This fluctuation would be a result of changes in caseload from the forecasted caseload for the fiscal year. However, the payments will still be reconciled against actual utilization, so the actual percentage of program value compared to actual utilization may result in a different percentage rate increase than the estimated rate increase, which is based upon historical utilization and estimated program values.

CMS Response (10/18/2021): Does the state direct the plans to set aside any portion of the capitation rate paid to them for this payment arrangement?

State Response (10/22/2021): No. The portion of the capitation rate attributed to each DPP has been separately identified and reported to the MCOs but no direction has been provided on how the MCOs should "set aside" these funds.

CMS Response (10/18/2021): Are the plans directed to use a specific portion of the capitation rates paid to them to pay out Component 1?

State Response (10/22/2021): No. The capitation rates have been calculated separately for each DPP; however, this add-on rate isn't delineated between the various components.

7. Please also revise the preprint to include the information on the reconciliation process described in Attachment A.

State Response (9/29/2021): Please see the changes in the attached pre-prints, per your request.

3. Can the state confirm that all payments (including the interim payments based on historical data) will be reconciled to actual utilization data during the rating period? Or will those initial interim payments remain based only on historical utilization?

State Response: All payments will be reconciled to actual utilization data during the final reconciliation.

CMS Response (9/24/2021): See CMS Round 3 responses, Question 4 above - CMS notes the process described in Attachment A seems highly complex and disruptive to providers while

removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.

State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

4. We will note that states that make interim payments based on historical utilization and then reconcile to actual data have noted that reconciliations like this can be administratively burdensome.

State Response: Noted. The importance of the program to our healthcare safety net is significant so HHSC will absorb the administrative burden.

CMS Response (9/24/2021): See CMS Round 3 responses, Question 4 above - CMS notes the process described in Attachment A seems highly complex and disruptive to providers while removing risk from the plans. The source of the complexity seems to be basing payments initially on historical utilization instead of current utilization. Can the state explain its preference for this approach? Why not instead base payments under Component 1 on current utilization; doing so would then seem to eliminate the need for processes 2 and 3 in Attachment A.

State Response (9/29/2021): The state may consider a change to payments based upon claims at the time of adjudication in the future. However, at this time, the administrative burden of making coding modifications to claiming systems for each of our MCOs, coupled with the shift in timing of payments to providers, outweighs the administrative burden that would be absorbed through the process described by the state. There will be risk experienced by the MCOs as their capitated payments will be based upon the historical utilization and if utilization varies, the MCO may have downward or upward risk.

5. CMS' understanding from previous responses is that the reconciliation threshold is a part of the state's administrative code. Can the state confirm that this change can be implemented without changes to the administrative code? If not, can the state describe the process and timing for making such changes? If changes to the administrative code are needed, will the state be able to implement those retroactively back to the start of the rating period?

State Response: Implementing this change will require the state to modify the Texas Administrative Code. HHSC will propose that rule changes will apply to the entire

program period, though the effective date of the rule change will be subsequent to the start of the rating period.

CMS Response (9/24/2021): Can the state elaborate the timeframes that would be needed to complete the state rulemaking process? Can the state also comment on if they anticipate challenges to the rulemaking and what impact those would have on implementation timelines?

State Response (9/29/2021): The Texas rulemaking process requires filing of a proposed rule with the Texas Register by Monday at noon to have the proposal published 11 days later (the second Friday after submission). Proposed rules are generally posted for a 30-day public comment period. Following the public comment period, the rule can be adopted with or without changes. Typically, a rule takes effect 20 days after the date the rule is filed with the Texas Register. This total process requires a minimum of 51 days; however, accounting for time necessary to prepare the rules for publication, to review public comments, and make any changes as a result thereof, HHSC typically assumes a minimum of 90 days will be necessary. HHSC anticipates receiving public comments but also anticipates that providers prefer changes be made if they are necessary for CMS approval for state fiscal year 2022.

For more information, CMS may wish to visit our webpage on rulemaking: https://www.hhs.texas.gov/laws-regulations/policies-rules/health-human-services-rulemaking.

CMS Response (10/18/2021): From the description above, it sounds like CMS would not expect rate amendments or contract amendments to implement the proposed changes until 90 days after the start of rulemaking at the state level. Is this correct?

State Response (10/22/2021): With respect to rule making changes described above, the state does not anticipate that rate changes or contract amendments would be required to implement the changes proposed for DPP for BHS, so the rates and contracts already filed with CMS will stand.

6. Can the state please describe how this new approach will be accounted for in the capitation rates? Will the directed payment be incorporated into the rates as a separate payment term? It would be helpful for the state to clarify how this new approach would impact the amounts included in the initial certification, and if the state and actuary intend to amend the rates in the future once the final payments based on actual utilization are known.

State Response: We expect that the DPP for BHS would continue to be incorporated as an adjustment to the base capitation rates and included in the monthly premium. Once final data is available at the end of the year, a retroactive adjustment to the DPP BHS capitation rates may be necessary, in which case HHSC would amend the MCO contracts and submit an actuarial rate amendment.

CMS Response (9/24/2021): See CMS Round 3 responses, Questions 1, 2 and 6. Appendix A, process 3 does not indicate that there will be any changes to the MCO payments and the state's response above states, "The MCOs will not experience recoupments as the capitated rates paid to the MCOs will include all necessary payments." However, this response indicates that retroactive adjustments to the capitation rates may be necessary. Can the state please

clarify if the state expects or anticipates an amendment to the rates and rate certifications may be needed and under what circumstances?

State Response (9/29/2021): The state does not anticipate making any prospective capitated rate changes based upon this modification. However, once final data is available at the end of the year, a retroactive adjustment to the capitation rates may be necessary if the degree of recoupments and redistributions is significant to the point that the capitated rates are no longer actuarially sound. If that occurs, HHSC would amend the MCO contracts and submit an actuarial rate amendment.

CMS Response (10/18/2021): The state indicates that there may be modifications to MCO payments if the redistributions are significant to a point that the resulting adjustments would no longer be considered actuarially sound. We would appreciate better understanding under what circumstances the MCO rates would be revised.

1. Can the state and its actuary please discuss how you are defining "significant" in this instance, and what threshold would trigger adjustments to the MCO capitation rates. Please address both the potential instances when MCOs are required to pay out more BHS payments than the amount of funding included prospectively in capitation rates, and when MCOs are required to pay out less BHS payments than the amount of funding included prospectively in the capitation rates.

   State Response (10/22/2021): The intent of any reconciliation would be to ensure that all MCO capitation rates continued to be considered actuarially sound and to ensure that no MCO was inadvertently harmed (or profited) due to shifts in utilization and provider payments that are beyond their control. The threshold for triggering a retroactive rate change is difficult to define in advance given that there are numerous variables that impact the capitation rates and would need to be taken into consideration. Without being overly prescriptive we believe that the risk margin would be the starting point for evaluating whether a modification would be necessary and that such consideration would be equivalent for the cases of both over and underpayment. There could be scenarios where the trigger could be higher or lower than the risk margin such as large scale utilization shifts that impact the overall profitability of the MCOs either positively or negatively resulting in variations in other assumptions that offset the need to adjust rates retroactively.

2. Since CMS evaluates actuarial soundness at a rate cell level, we would appreciate understanding if the state and actuary intend to review whether adjustments to the rates are necessary as a result of the reconciliation at a rate cell level. If not, we would appreciate understanding why not, and at what level the state intends to perform the analyses to determine if adjustments to the rates are necessary.

   State Response (10/22/2021): Our intent would be to evaluate the need for any rate adjustments at the same level of detail on which the capitation rates are set, i.e. at the MCO, SDA and risk group level.

3. To the extent the state and actuary determine that adjustments to the MCO capitation rates are necessary as a result of the reconciliation, we would appreciate understanding if the state intends to still include a risk margin provision in the revised BHS amounts included in the rates based on the reconciliation. If the state intends to still include a risk margin when developing revised BHS amounts based on the reconciliation, we would appreciate understanding why this is reasonable.

State Response (10/22/2021): In general, risk margins are set by program and applied uniformly across all components of the premium rate, i.e. medical, pharmacy, QIPP, CHIRP, etc…The margins are not necessarily intended to reflect the risk associated with each individual claim type, risk group, SDA but an aggregate reflection of the risk across the entire program inclusive of all services and rate components. For this reason, we believe that a risk margin may still be necessary as this assumption is set in aggregate and not specific to the BHS. This assumption may need to be reevaluated given the specific circumstances in the event a rate adjustment is necessary.

7. As part of Round 2 during the preprint review, the state provided a revised total dollar amount of $176,400,019 for this directed payment; however we do not believe the state provided a revised preprint updating the amount of the payment, or the other parts of the pre-print such as the reimbursement rate analysis. Can the state please confirm that this total dollar amount is still accurate given the new reconciliation approach and submit a revised preprint accounting for this total dollar amount?

State Response: During the calculation for this program's capitation payments, the state found that some providers had not submitted all associated NPI numbers on their program applications therefore skewing those provider's payments (NPIs are used to pull claims for historical utilization). After the correct NPIs were collected, the model calculated new payments from updated historical utilization using the same methodology. The final program total is $176,400,019. See below for the updated breakout:
Component 1: $108,324,269
Component 2: $57,681,357
Administration, profit margin and premium tax: $10,394,393

This information is also provided in an updated preprint.

CMS Response (10/18/2021): The state's rate certification(s) appear to include $180,740,784 for this state directed payment. Is this an older estimate and does the state expect to revise this amount in the preprint?
State Response (10/22/2021): The change in program value from $180,740,784 to $176,400,019 is due to the exclusion of 3 providers that were determined to not yet be eligible after the FY2022 capitation rates were calculated, actuarial reports drafted and submitted to CMS. Given the relatively small size of this reduction we do not believe an adjustment is needed to the capitation rates.

CMS Response (9/24/2021): Can the state confirm that the provider payment level analysis provided in the preprint reflects these changes? If not, please provide an updated preprint with an updated provider payment level analysis that reflects these changes.
State Response (9/29/2021): The pre-print has been updated to reflect this information.

2. Require that any payments be based on performance linked to Medicaid managed care enrollees only (not Medicaid FFS), and performance-based payments must ensure that

providers are achieving year over year improvement in accordance with the regulatory requirement that the arrangement must advance managed care quality goals and objectives.

State Response: The state believes the payments are based on performance linked to Medicaid managed care enrollees. HHSC has developed a hybrid model that requires providers to meet program quality requirements, but where payment is still triggered by Medicaid managed care utilization. For example, in the TIPPS Component 3 and DPP BHS Component 2, once a provider has demonstrated achievement on their measures, they are eligible to earn payments. The payments are rate enhancements paid upon claims adjudication of certain codes identified in the program requirements. On the August 24, 2021 call with Texas, CMS indicated this was not clear in the preprint. Could we maintain the quality descriptions in our pre-print submissions, as we hope to transition toward more value-based DPPs in the future, but change the selection under question 10 to remove "Quality Payment/Pay for Performance" but leave "Medicaid-Specific Delivery System Reform" and "Performance Improvement Initiative"? Or does CMS have suggestions for other changes Texas could make to the pre-print to address this issue?

Should CMS want to restrict measurement to only Medicaid managed care members, HHSC would propose to transition over the first year of the program so that providers are able to make necessary system changes to stratify by Medicaid managed care only, and HHSC would need to amend the selection of measures used for tracking provider quality improvement, such as the structure measures or hospital safety measures.

8. Is this a requirement that only applies to Pay-for-performance measures in a value-based DPP? Or would it also apply to provider-reported measures used for evaluations?

CMS Response: From recent discussions with the state, we understand that Component 2 should be classified as a uniform increase and not a pay for performance arrangement as the condition of payment is the submission of a claim rather than performance on a quality measure. Can the state please confirm this is correct? Additionally, can the state confirm that payment will be made per claim during the rating period and not based on historical claims?

State Response: Yes, this is correct (though Texas wishes to note that we view this component of a hybrid approach wherein eligibility for the uniform rate increase is made with consideration of quality-based achievements); however, for purposes of CMS review of the pre-print and regulatory compliance, this component is most appropriately considered uniform rate increase. The payments will be made per claim during the rating period and not based on historical claims. The increased rate will be paid at the time of claim adjudication.

As previously noted, CMS does expect measurement to be restricted to only Medicaid managed care members for pay for performance arrangements and provider-reported measures for evaluation.

State Response: Yes, rate increases will be applied to adjudicated claims specified in the preprint. The providers will only be eligible for these rate increases if the providers have demonstrated achievement on the performance measures, but the payments will only be released on the submission of the specific claims. In component 2, the payment will be made as a rate increase per claim during the rating period and not based on historical claims.

With regard to year-over-year improvement

9. HHSC assumes this applies to provider-level pay-for-performance measures in addition to evaluation measurement at the Medicaid-member level. Is that correct? **CMS Response**: Yes, the SDP should aim to have year-over-year improvement in the evaluation measures at the SDP-level (i.e., across all the providers participating in the SDP) as noted earlier in response to QIPP.

    State Response: As proposed, the first year of these programs will establish baselines. The state will consider this in setting goals in the year 2 evaluation plan.

CMS Response (9/24/2021): CMS' understanding is that each of the preprints listed here have moved to include only uniform increases where payment is conditioned upon utilization and not performance. If any of these proposals condition payment upon performance, then changes to account for this will need to be made in alignment to feedback previously provided. See comments above related to QIPP.

State Response (9/29/2021): The State confirms that CMS' understanding is correct. In Year 1 all components of CHIRP, TIPPS, RAPPS, and DPP for BHS will be uniform increases where payment is conditioned upon utilization and not performance. In QIPP, Components 2, 3, and 4 will remain value based payments conditioning payment upon performance.

10. How should this apply to structure measures currently included in the program? **CMS Response:** As noted earlier, CMS strongly encourages states to use outcome measures for value-based payments. Using structural measures does not necessarily lead to health improvements for Medicaid beneficiaries. Using structure or count measures along with outcome measures can, however, show the importance of ensuring adequate staffing on health outcomes of beneficiaries, especially when done over time. We encourage Texas, therefore, to use these measures along with outcome measures that are measuring the impact of the healthcare. Also process measures, such as vaccine administration, can be used with outcome measures.

    State Response: The state has included structure, process, and outcome measures in DPP BHS. We will continue to do so, as the structures are encouraging DSRIP-informed best practices that impact improvement in health outcomes. It is our understanding that CMS does not require year-over-year improvement in structure measures and prefers process and outcome measures for the pay-for-performance components of these programs.

CMS Response (9/24/2021): Thank you for the state's response. CMS' understanding is the state has revised this preprint so that the payments under this payment arrangement are no longer conditioned upon performance. CMS' understanding is the inclusion of structure, process and outcomes measures for TIPPS refers to the evaluation of the payment arrangement and/or provider eligibility for the class. If this is incorrect and any component of TIPPS requires payments conditioned upon performance, the guidance provided earlier for QIPP Components 2-4 would apply.

State Response (9/29/2021): Noted. The State confirms that CMS' understanding is correct and in Year 1 DPP for BHS will not include any payments conditioned upon performance.

11. Texas DPPs feature measures intended exclusively as improvement over self (IOS) measures or benchmark measures. If a measure is exclusively a benchmark measure, is it not acceptable for a provider to maintain performance above the benchmark? **CMS Response**: As previously discussed under QIPP, where payment is conditioned upon performance on a quality measure and the state wants to use a set benchmark that a provider must achieve to earn payment (e.g., a statewide or national benchmark), the state must adopt a requirement that if the provider already was achieving the benchmark at the start of the performance period, they would have to demonstrate period over period performance (e.g., year over year or quarter over quarter). We recognize that there may be high-achieving providers that already surpassed the benchmark and show moderate fluctuations in performance that are natural fluctuations in performance. To address this, we would recommend that when measuring performance over self, the state allow for maintaining performance within the trend for the national benchmark for each measure.

State Response: The state will assess using IOS goals for providers who are performing above the benchmark goal. For CHIRP, DPP BHS, RAPPS, and TIPPS, the requirement to demonstrate year-over-year improvement is something that will be evident in the evaluation and structure of the second year of these programs. As proposed, the first year of these programs will establish baselines.

CMS Response (9/24/2021): Thank you for the state's response. CMS' understanding is the state has revised this preprint so that the payments under this payment arrangement are no longer conditioned upon performance. CMS' understanding is the inclusion of structure, process and outcomes measures for TIPPS refers to the evaluation of the payment arrangement and/or provider eligibility for the class. If this is incorrect and any component of TIPPS requires payments conditioned upon performance, the guidance provided earlier for QIPP Components 2-4 would apply.

State Response (9/29/2021): Noted. The State confirms that CMS' understanding is correct, and in Year 1 DPP for BHS will not include any payments conditioned upon performance.

12. Would maintenance of a rate of performance for a high performer be acceptable? **CMS Response:** We recognize that there may be high-achieving providers that already surpassed the benchmark and show moderate fluctuations in performance that are natural fluctuations in performance. To address this, we would recommend that when measuring performance over self, the state allow for maintaining performance within the trend for the national benchmark for each measure. For example, if the national or statewide benchmark dipped by 1% from the previous period to the current period, providers who are already over the benchmark and maintained their performance measured at the individual facility level within a margin of +/-1 percent or improved by more than that would earn payment; if the same facility declined in performance by more than 1%, they would not receive payment even if their performance is over the benchmark.

State Response: As proposed, the first year of these programs (CHIRP, DPP BHS, RAPPS, and TIPPS) will establish baselines. As such, the state will not make these adjustments in administrative rule or the preprints at this time. Thank you for recognizing the option for maintenance of a high-performance rate. HHSC will

consider the CMS recommendation for its second-year program designs. The requirement to demonstrate year-over-year improvement will be evident in the evaluation and structure of the second year of these programs.

CMS Response (9/24/2021): Thank you for the state's response. CMS' understanding is the state has revised this preprint so that the payments under this payment arrangement are no longer conditioned upon performance. CMS' understanding is the inclusion of structure, process and outcomes measures for TIPPS refers to the evaluation of the payment arrangement and/or provider eligibility for the class. If this is incorrect and any component of TIPPS requires payments conditioned upon performance, the guidance provided earlier for QIPP Components 2-4 would apply.

State Response (9/29/2021): Noted. The State confirms that CMS' understanding is correct, and in Year 1 DPP for BHS will not include any payments conditioned upon performance.

13. Refine the evaluation plan for BHS to ensure that the effect of the BHS state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.

State Response: The state is working with our EQRO contractor to refine an attribution methodology for each program. There are some measures included in the evaluation which cannot be limited to providers participating in the DPP. Some of the measures that cannot be attributed exclusively to one DPP provider are CMS core set measures recommended by CMS for DPP evaluations. In light of the call with Texas on August 24 and CMS' acknowledgement, we will proceed with maintaining the CMS core set measures selected for the respective evaluations, even though they cannot be attributed only to providers participating in the corresponding DPPs. HHSC is open to providing one annual DPP evaluation which breaks out DPP-specific attribution measures, as CMS suggested in the August 24, 2021call with Texas.

14. Does CMS have any other recommendations for how to isolate the impact of the DPP other than the work HHSC is undertaking with its contractor to do so? **CMS Response:** Please refer to the overarching comments at the top of this paper.

State Response: Please refer to our responses to CMS's overarching comments.

With respect to baseline year, in a phone call on January 27, 2021 with CMS, HHSC proposed using CY 2020 and CY2021 as baselines because of the timing of the beginning of the program (CY 2021 would include 4 months of the start of the program) and the impact of COVID. Using the two years was intended to capture that context for future measurement. CMS indicated the proposal made sense. If CMS prefers that we use only one year, HHSC could use CY 2021 for the new DPP BHS evaluation measures. However, this would delay further any evaluation of the programs because of data lags (please see page 4-5 of the DPP BHS updated evaluation plan for timeline of available data).

With respect to year-over-year improvement, it is the state's goal to have improvement year-over-year, but we are also cognizant of not being able to set goals at this point because of the unknown impact of the PHE.

15. Does CMS have a recommendation for how the state can address this issue in the evaluation plan? **CMS Response**: CMS recognizes all healthcare systems have been impacted by COVID and that year-over-year improvement will be challenged by the PHE. We take that into consideration in our review of quality improvement efforts. We anticipate that the PHE will be part of the narrative and outcomes of the SDP evaluations including how COVID impacted the evaluation findings.

    State Response: We will include this in the submitted evaluation discussion. Does CMS have concerns with the goals and targets we have included in the plans?

CMS Response 9/24/21: Our concern is that the state has not identified any overall quality improvement targets for the SDPs. The state will need to provide those overall quality improvement targets (for each measure) for SFY 2023; that timeframe allows the state to see 2021 data and adjust for COVID.

State Response (9/29/2021): As acknowledged by CMS, the SFY2022 preprints will not include improvement targets as baseline data is pending. The State will include initial improvement targets for achievement in CY2022 in the SFY2023/Year 2 preprint submissions. However, the State may submit an addendum to update these improvement targets during SFY2023 after CY2021 data are available (estimated in summer/fall 2022).

16. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable? **CMS Response:** We recognize that there may be high-achieving providers that already surpassed the benchmark and show moderate fluctuations in performance that are natural fluctuations in performance. To address this, we would recommend that when measuring performance over self, the state allow for maintaining performance within the trend for the national benchmark for each measure. For example, if the national or statewide benchmark dipped by 1% from the previous period to the current period, providers who are already over the benchmark and maintained their performance measured at the individual facility level within a margin of +/-1 percent or improved by more than that would earn payment; if the same facility declined in performance by more than 1%, they would not receive payment even if their performance is over the benchmark.

    State Response: As proposed, the first year of these programs (CHIRP, DPP BHS, RAPPS, and TIPPS) will establish baselines. As such, the state will not make these adjustments in administrative rule or the preprints at this time. Thank you for recognizing the option for maintenance of a high-performance rate. HHSC will consider the CMS recommendation for its second-year program designs. The requirement to demonstrate year-over-year improvement will be evident in the evaluation and structure of the second year of these programs.

CMS Response (9/24/2021): CMS' understanding is that each of the preprints listed here have moved to include only uniform increases where payment is conditioned upon utilization and not performance. If any of these proposals condition payment upon performance, then

	changes to account for this will need to be made in alignment to feedback previously provided. See comments above related to QIPP. **State Response (9/97/2021):** The State confirms that CMS' understanding is correct. In Year 1 all components of CHIRP, TIPPS, RAPPS, and DPP for BHS will be uniform increases where payment is conditioned upon utilization and not performance. In QIPP, Components 2, 3, and 4 will remain value based payments conditioning payment upon performance. **CMS Response (9/24/2021):** The revised preprint for BHS includes the following sentence in the response to Question 8, "Texas will discuss with CMS specifics related to Component 3 on the call scheduled for September 16, 2021." Please revise the preprint to remove this sentence. **State Response (9/97/2021):** The State has removed the sentence in the updated Question 8.
Sources of Non-Federal Share (IGTs, Bonds, and Debt Instruments)	CMS and the state must ensure that sources of non-federal share (including bond revenues, and other debt instruments, that localities use to source inter-governmental transfers) comply with section 1903(w) of the Social Security Act and implementing regulations at 42 CFR Part 433. 1. Please confirm that Texas currently does not collect information related to the entities that purchase bonds (and other debt instruments) that are used to finance the non-federal share of Medicaid payments from localities that provide inter-governmental transfers. **State Response:** Texas confirms this statement. **CMS Response:** Thank you for confirming. CMS continues to have concerns over the use of bond and other debt instrument revenues as the source of IGTs used to finance the non-federal share of Medicaid payments to the extent private Medicaid providers (or provider-related entities) participate in such financing and receive Medicaid payments. We advise Texas to develop an oversight plan that examines the underlying sources of local non-federal share that rely on bonds or other debt instruments, including gathering the information described in question #2 below for bond or other debt instruments that involve financing Medicaid payments, to understand whether and how Medicaid providers (or provider-related entities) are participating in the arrangements through the purchase of bonds or other debt instruments and/or the receipt of payments supported by the revenue raised. State Response: Thank you for this feedback; we are glad that this matter can be considered closed for the purposes of consideration of our pending SDP approvals. Texas will take this under advisement as the monitoring protocols are finalized. 2. Please provide an assurance that Texas will develop an oversight plan for local non-federal share financing, whereby the state will collect and maintain information from localities detailing (at a minimum): a. The names of entities that purchase bonds (or other debt instruments) used to finance the non-federal share of Medicaid payments. b. Identification of any providers or provider-related organizations that are bond (or other debt instruments) purchasers. c. Identification of any providers or provider-related organizations that are bond (or other debt instruments) purchasers and that either: receive Medicaid payments directly or are within a provider class that receives Medicaid payments.

d. For any entity identified under (c), the total dollar amount of the bonds (or other debt instruments) the entity purchases and the amount of Medicaid payments the entity (or provider class) receives.

State Response: Texas is developing a comprehensive monitoring and oversight plan for local funds used in the Medicaid program. To the extent that a local or state governmental entity is in possession of information about bond purchasers (or other debt instruments), Texas would be willing to obtain and provide this information to CMS. However, as discussed on the August 20, 2021 call between Texas and CMS, Texas is unsure that governmental entities that have bonds issued by an underwriter or financial institution who sells the bonds through a normal bond market would be in possession of this information. As a result, Texas requests that CMS provide to Texas for use in the development of the oversight plan:
(1) a clear description of the circumstances in which the information sought above is required (I.e. for all bond offerings by a governmental entity or only for a bond issued for specific purposes);

CMS Response: CMS is not requesting Texas report this information to CMS at this time. We advise the state to conduct oversight on the sources of non-federal share that are used to finance Medicaid payments and to thoroughly understand the underlying sources of financing that localities rely upon to source IGTs. Based on information previously provided by the state, there appear to be at least 9 entities (listed below) that may rely on bonds or other debt instruments as a source of revenue to fund IGTs that are used as the state's non-federal share of Medicaid expenditures. We would urge the state to examine the sources of financing that these entities use to source IGTs as a starting point in your oversight efforts and to further work with localities to identify where bonds or other debt instruments are used to finance the non-federal share of Medicaid payments.

SDA	Name of IGT Entity
Dallas	Dallas County Hospital District (Parkland)
MRSA West	Texas Tech University Health Science Center-Permian Basin
Lubbock	Texas Tech University Health Sciences Center AMA
CORYELL COUNTY MEMORIAL HOSPITAL AUTHORITY	
DECATUR HOSPITAL AUTHORITY	
FANNIN COUNTY HOSPITAL AUTHORITY	
SMITHVILLE HOSPITAL AUTHORITY	

UVALDE COUNTY HOSPITAL AUTHORITY	
Metrocare	

State Response: Thank you for this feedback; we are glad that this matter can be considered closed for the purposes of consideration of our pending SDP approvals. Texas will take this under advisement as the monitoring protocols are finalized. Texas does wish to clarify that the notation in TIPPS that Dallas County Hospital District (Parkland) does not have taxing authority was made in error; Parkland does have authority to levy ad valorem taxes. Additionally, while Tech Texas University's specific campuses noted in our submissions do not directly receive appropriations from General Revenue, The Texas Tech University System does receive appropriations and uses those appropriations to fund the operations of the campuses, including the two campuses referenced here, under their authority.

(2) a clear description of an exemption to the requirement of providing this language if a governmental entity can attest that they are not in possession of and have no knowledge of who has purchased the bonds, if the bonds are available for purchase to the general public through a routine bond issuing transaction; and

CMS Response: While there may be circumstances where bonds or other debt instruments are routine and generally available for the general public to purchase that would not involve a non-bona-fide provider related donation, we do not believe that an attestation by a government entity that it does not have knowledge of the purchasers of its bonds or other debt instruments would be sufficient to ensure state compliance with federal statutory and regulatory limitations on the permissible sources of non-federal share. We urge Texas to gather information from local entities that contribute to the non-federal share of Medicaid payments, so the state has a full accounting of the entities, including bond and other debt instrument purchasers whose purchase funds support IGTs, that contribute to the financing. To the extent that a locality has information to substantiate an attestation that providers or provider-related entities are not participating in bond or debt instrument issuances, such an attestation may be sufficient evidence of compliance with federal requirements concerning non-bona fide provider-related donations.
State Response: Thank you for this feedback; we are glad that this matter can be considered closed for the purposes of consideration of our pending SDP approvals. Texas understands that CMS, per CMS' statements above, is not requiring this information to be furnished at this time or for approval of the SDPs and is offering this feedback for Texas' consideration as the Local Funds Monitoring protocols are developed. We look forward to finalizing our protocol in cooperation with local governments in Texas and sharing the finalized protocols with CMS in due time.

(3) clarity on how frequent this reporting would be due.

CMS Response: We again clarify that CMS is not suggesting that the state furnish this information to CMS on any regular basis; rather, the state should gather and review the information to ensure compliance with federal requirements and support claims for federal financial participation. CMS is only seeking for Texas to conduct sufficient oversight to

	ensure it can credibly assure that it is complying with federal statutory and regulatory requirements for federal financial participation. Given the questions that surround the use of bonds and debt instruments and concerns over non-bona-fide provider related donations, gathering such information is crucial for state oversight to ensure compliance with federal requirements. In addition, communicating expectations to localities on their responsibilities to ensure compliance with federal Medicaid requirements is important when localities are providing funds to the state to support the non-federal share of Medicaid payments. We suggest that Texas work with localities on the timeframe for gathering information necessary to support compliance with non-federal share financing requirements and that the state receive this information in alignment with the timing of transfers from localities to the state Medicaid agency through IGTs. To the extent that Texas holds IGT agreements with local entities that contribute to the non-federal share of Medicaid payments, the state might consider modifying the agreements to require the provision of information on the underlying source(s) of the transferred funds on a specified schedule. State Response: Thank you for this feedback; we are glad that this matter can be considered closed for the purposes of consideration of our pending SDP approvals. Texas understands that CMS, per CMS' statements above, is not requiring this information to be furnished at this time or for approval of the SDPs and is offering this feedback for Texas' consideration as the Local Funds Monitoring protocols are developed. We look forward to finalizing our protocol in cooperation with local governments in Texas and sharing the finalized protocols with CMS in due time. Texas does not have any agreements with local entities to contribute the non-federal share for SDPs, but if any are developed in the future, we would take this guidance under consideration. 3. CMS understands that the state is in the process of setting up an oversight group related to the financing mechanisms described in this state directed payment preprint. Please describe steps in the near-term that the state will use to effectively oversee how these program payments are funded by the state or local units of governments. **State Response:** S.B. 1 (Article II, Health and Human Services Commission, Rider 15), 87th Texas Legislature, Regular Session, 2021, authorizes additional staff to HHSC for increased monitoring and oversight of the use of local funds and the administration of new directed-payment programs. Texas plans to utilize the resources to implement additional oversight and monitoring as described in Attachment B. **CMS Response:** Thank you for this information, we will consider it with the other information you provide in reviewing your requested State Directed Payments. State Response: Noted.
Sources of Non-Federal Share (Locality Taxes and LPPFs)	To ensure compliance with section 1903(w)(4) of the Social Security Act and implementing regulations in 42 CFR 433.68(f)(3), please provide the following: 1. A table using the most recent data available to the State, of every LPPF in the State, including the name of the unit of local government that operates the LPPF, the hospitals that are taxed in the LPPF, and the amount that each hospital is taxed, and the amount of payments funded by the tax.

State Response: Since there was no additional feedback or questions from CMS on this item, Texas understands that this matter can be considered resolved for the purposes of consideration of our pending SDP approvals.

State Report: Please see Attachment C, which is the most recent final data we have at this time.

2. Written attestation from the state that:
   a. No localities impose a tax where all hospitals paying the tax receive their total tax cost back in the form of Medicaid payments funded by the tax (including localities that impose a tax on a single hospital).
   b. No localities impose a tax on hospitals that are not located within the boundaries of their jurisdiction.
   c. That the state will actively oversee how the locality taxes and LPPF arrangements meet federal requirements on an ongoing basis.

State Response: The state attests that the above is true and accurate. With respect to item (2)(c), HHSC clarifies that HHSC does not have regulatory authority over nor oversees the operation of any LPPF. As a result, HHSC is limited to actively overseeing the arrangements for the specific and exclusive determination that the revenues transferred to HHSC for use in the Medicaid program meet applicable state and federal requirements for using funds in the Medicaid program.

3. Written attestations from all participating hospitals that they do not participate in arrangements, through written agreements or otherwise, which involve participating hospitals transferring, redirecting, redistributing (including through pooling arrangements) Medicaid payments to other Medicaid providers, directly or indirectly.

State Response: The state takes seriously its responsibility to ensure compliance with all federal financing requirements. In compliance with the relevant statute and CMS's published rulemaking and state reporting requirements, the state has implemented an LPPF monitoring requirement to ensure that units of local government with authority to operate an LPPF do not have any statutes, regulations, or policies that could constitute such a guarantee.
However, it must be noted that the law CMS purports to be enforcing refers to arrangements in which the State or other unit of government imposing the tax provides for any payment that guarantees to hold taxpayers harmless. As CMS explained in its February 2008 final rule, "the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy." 73 Fed. Reg. 9694. Neither § 1903(w)(4) nor § 433.68(f)(3) give CMS the authority to regulate (or to require States to regulate) transactions between private providers in which the State is not involved. Therefore, Texas requests that CMS clarify the following:
(1) Given that CMS withdrew the proposed rule that would have expanded the circumstances in which a direct guarantee will be found to exist, what is CMS's legal authority for finding a direct guarantee when a governmental entity is not a party to the arrangement?

	(2) Can CMS provide the statute or regulation that specifically restricts or directs how a Medicaid provider may use reimbursements received for services delivered in the Medicaid program once received by the provider? CMS Response: 1. CMS is concerned that a hold harmless arrangement as described in section 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f) exists if a locality imposes a health care-related tax in which all taxpaying hospitals receive their total tax cost back in the form of Medicaid payments or other payments. The state recently affirmed that no localities impose a tax where hospitals receive some or all of their tax cost back in the form of Medicaid payments. However, the state did not provide complete data requested by CMS to support its affirmation (i.e., based on the most recent data available to the state, identifying every LPPF in the state, including the name of the unit of local government that operates the LPPF, the hospitals that are taxed, and the amount that each hospital is taxed, and the amount of Medicaid payments funded by the tax made to each hospital). Please provide the requested data or explain why it is unavailable. In either case, please explain how the state is able to affirm that no localities impose a tax where taxpaying hospitals receive their total tax cost back in the form of Medicaid payments if it does not have and/or has not considered the requested information. State Response: The state reaffirms our prior attestation that items 2(a), (b), and (c) of this subsection of correspondence is true and accurate. With respect to item (2)(c), HHSC again clarifies that HHSC does not have regulatory authority over nor oversees the operation of any LPPF. As a result, HHSC is limited to actively overseeing the arrangements for the specific and exclusive determination that the revenues transferred to HHSC for use in the Medicaid program meet applicable state and federal statutes and regulations for using funds in the Medicaid program. As described on our call on September 1, 2021, Texas understood the attestation to the first portion of the items described above to speak to a guarantee in payment methodology for programs funded by intergovernmental transfer funds to consider the source of the IGT (who has paid into a provider tax) to ensure that the providers all receive sufficient Medicaid payments to offset the amount of their taxation. None of the program methodologies consider the source of the funds which is why Texas felt comfortable attesting. Additionally, for the proposed SDPs, like in the Uncompensated Care Program, IGTs received from local entities are pooled by service delivery area so it is not possible to directly tie IGT received by the state that is funded via an LPPF assessment to the Medicaid payments received by a provider as the dollars are not used in a one-to-one relationship (i.e. payments are not conditioned upon receipt of IGT).

However, due to CMS' clarification that CMS wished the state to examine whether entities that are subject to a mandatory payment to a local government through an LPPF happen to receive payments equivalent or exceeding the amount received by the hospitals in that area from Medicaid payments, Texas undertook the analysis, though the results have no bearing on the determination that a hold harmless exists or not. When completing the analysis using Fiscal Year 2020 (the most recent year for which there is a complete year of data for both Medicaid payments and LPPF-related reporting), there were 28 entities that had authority to operate an LPPF. Of the 28 entities that had authority to operate, 26 were active and assessed mandatory payments on providers in their respective jurisdictions. Of the 26 that assessed mandatory payments, there was at least one hospital in the jurisdiction that did not receive Medicaid payments in an amount greater than or equal to the amount paid by the entity to the LPPF.

In the case of the 2 jurisdictions (Ellis and McClennan Counties) where the providers all received Medicaid payments in an amount that exceeds the amount paid by those hospitals to the Governmental Entity operating the LPPF, the non-federal share required to support the Medicaid payments made to those providers far exceeds the total amount paid via assessment for the LPPF. In the case of Ellis County, more than 28 percent of the non-federal share necessary to support the payments to the providers exceeds the amount paid by the hospitals to the Governmental Entity operating the LPPF. In the case of McClennan County, more than 37 percent of the non-federal share necessary to support the payments to the providers exceeds the amount paid by the hospitals to the Governmental Entity operating the LPPF. Therefore, there is clear evidence that the receipt of Medicaid payments is unrelated to the amount of funds paid by the Provider to the Governmental Entity operating the LPPF, consistent with HHSC's prior representations that no direct guarantee between LPPF-related payments to a local government and the amount of Medicaid payments received by the hospital exists. The Medicaid payments to those hospitals were clearly supported by non-LPPF-related non-federal share funds transferred by an entity using public funds exceeding collected LPPF paid assessments and no direct or indirect guarantee exists. Mandatory LPPF receipts are wholly unrelated to the payment methodologies used by HHSC. HHSC believes strongly that this is clear evidence that no hold harmless arrangement exists between the local government or the state for those providers.

A copy of the analysis described above can be found in Attachment B.

CMS Response (10/18/2021): CMS remains concerned that a hold harmless arrangement as described in section 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f) exists if a locality imposes a health care-related tax in which

		all taxpaying hospitals receive their total tax cost back in the form of Medicaid payments or other payments. We recognize that HHSC maintains that it does not have regulatory authority over nor oversees the operation of any LPPF. Has the state or HHSC enacted, issued, or provided any statutory requirements, regulations, policy guidance, or training to localities regarding which localities are eligible to impose health care-related taxes in Texas? If so, please explain and provide documentation as applicable. **State Response (10/22/2021)**: As CMS is aware, there are two jurisdictions where all hospitals subject to the tax receive Medicaid payments in excess of their LPPF tax burden. HHSC has demonstrated that the Medicaid payments hospitals receive in these jurisdictions are (1) not positively correlated to the tax amount or to the difference between the Medicaid payment and the tax amount, (2) do not vary based on the tax amount, and (3) neither the state nor local government imposing the tax provides any direct or indirect guarantee that the provider will be held harmless for the tax amount. As a result, HHSC understands the funds from these jurisdictions to be permissible provider taxes eligible to be used as the non-federal share. Each governmental entity with individual authority to operate a LPPF is granted such authority through statute. See Texas Health and Safety Code, Chapter 288 *et seq*. During the 86th regular session, The Texas Legislature authorized any locality with taxing authority to move forward with an LPPF on a limited basis. To date, no additional entities have pursued establishing an LPPF outside those specifically authorized through individual legislation. With regard to training and policy guidance, since as far back as spring of 2019, HHSC has reiterated its willingness to work with CMS on how the newly established Local Funds Monitoring team should conduct its oversight. CMS has not provided feedback to that end. However, as CMS is aware from our prior responses, HHSC has begun to develop a monitoring plan, sought public comment, and continues to identify potential inquiries, training, data collection, on-site visits, and a robust annual survey for all local governmental entities that provide non-federal share funds through IGT or CPE. Like CMS, HHSC's goal is to ensure that local governments are providing permissible funding as the non-federal share. HHSC seeks to ensure that no local government is involved in any arrangement that would lead its funds to be impermissible for use in the Medicaid program. HHSC remains open to collaboration with CMS to thoroughly carry out this mission to the extent supported by federal and state statutes and regulations. 2. In accordance with 1903(w)(6) of the Social Security Act and the implementing regulations at 42 CFR 433 Subpart B, CMS has requested copies of "mitigation agreements" or similar agreements in place between or among

LPPF-participating providers and/or the LPPF, to ensure that health care-related taxes imposed by Texas localities that generate funds used as the source of the state's non-federal share of Medicaid payments, meet statutory and regulatory requirements. CMS is concerned that these agreements may be part of a hold harmless arrangement that would violate section 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f)(3) because there appears to be a "reasonable expectation" that the taxpaying hospitals – whether directly through their Medicaid payments or due to the mitigation agreements or other agreements – are held harmless for at least part of their tax cost.

Absent copies of these agreements, CMS requests the state provide CMS an assurance, through an attestation, that no arrangement exists, through written agreements or otherwise, which involves participating hospitals transferring, redirecting, and/or redistributing (including through pooling arrangements) their payments supported by the tax to other Medicaid providers, directly or indirectly. CMS further requests the state obtain the necessary information from each LPPF-participating provider and/or the LPPFs, as the state may need, to support the state's attestation that no such arrangements exist.

State Response:
Texas attests that all units of government and the hospitals within their jurisdictions are in compliance with 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f). Texas attests the units of local government imposing a mandatory payment (a.k.a. Local Provider Participation Fund (LPPF)) do not provide for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly guarantees to hold taxpayers harmless for all or any portion of the tax amount. Texas attests that neither the state or any unit of local government within the state issue a payment directly or indirectly to any participating hospitals such that the hospital could compel an agreement from another hospital to transfer, redirect, and/or redistribute (including through pooling arrangements) payments supported by LPPF revenues.

CMS Response (9/24/2021): Thank you for the responses and additional information provided on the LPPFs for the round 2 responses. Based on the review of this information, we have a few additional questions:

1. On our call on 9/20/2021, the State of Texas explained that one reason why Attachment C, provided on 8/25/2021, may have listed LPPFs in some counties as not having any assessed hospitals is that these counties had newly instituted LPPFs and the data provided covered only one quarter (3rd quarter FY 2021). However, in Attachment B that the State of Texas provided on September 15, 2021, which covers an entire fiscal year, FY 2020 (Attachment B provided), 36 hospitals do not appear to be taxed. Please explain why the 36 hospitals in Attachment B are not listed as being taxed if the tax is broad-based and applies to all private providers?

State Response (9/29/2021): In Attachment B, there are 36 instances where there is no entry under the "LPPF Paid Amount;" however, our review of the data sheet shows that 24 of those blanks do not indicate a facility paid no tax:

- 9 of those blanks represent Cherokee County and Nueces County Hospital District, both of which Texas disclosed had LPPF taxing authority, but did not implement an assessment for FFY 2020, so we would expect those to be blank.
- 3 of the rows were blank, where the entire row was unintentionally included, but blank all the way across (Lines 151, 280, and 309).
- 5 blanks seem to be sub-parts of hospitals that were assessed, and paid a mandatory assessment – we will confirm that with the impacted local governmental entities (Lines 83 and 84 are labeled as "part of Texoma Medical Center," Line 269 appears to be part of Mother Frances Hospital, and Lines 270 and 271 appear to be part of UT Health East Texas).
- 7 blanks list duplicative TINs or TPIs for entities which all paid the mandatory assessment, as shown in the line immediately preceding or following such blank, (Lines 29, 132, 160, 193, 194, 257, and 258), and none of which represent a separate entity.

There are 12 facilities listed that did not have an LPPF payment reported. As CMS knows, Texas has been working diligently to create and staff a local funds monitoring team, which will be responsible for researching and determining the cause of these types of data anomalies. While each local government is already bound by Texas statute to assess the LPPF uniformly to applicable facilities, the local funds monitoring team will communicate with each local government to (1) ensure the tax assessments were appropriately administered, and (2) confirm that each local government is following its statutorily required collection procedures for any delinquent taxpayers. Based on our understanding from the local governments participating in the program, tax assessments are levied in accordance with the applicable LPPF enabling statute; therefore, we should infer that any unpaid mandatory assessment shown in the data is a reporting or data error, or is being pursued in accordance with local rules.

LPPF Governmental Entity	Facility	Explanation of Non-Payment of LPPF for FFY 2020
Bexar County Hospital District	Clarity Guidance Center	The mandatory payment in this jurisdiction is imposed on providers that provide inpatient hospital services (Texas Health and Safety Code Chapter 298F). Pursuant to 42 C.F.R. Sec. 440.10, inpatient hospital services are limited to institutions meeting the requirements to participate in Medicare as a hospital. This provider does not meet the requirements to participate in Medicare, is not required to make mandatory payments, and was erroneously included as a paying facility.

El Paso County Hospital District	Foundation Surgical Hospital of El Paso Foundation Hospitals	Taxpayer is Delinquent – HHSC has verified documentation showing collection attempts.
El Paso County Hospital District	Rio Vista Behavioral Health	New Facility – did not have sufficient data on which to base an assessment during FFY20.
Harris County Hospital District	Altus Baytown Hospital	Taxpayer is Delinquent – HHSC has verified documentation showing collection attempts.
Harris County Hospital District	UMMC Providence Hospital of North Houston LLC	Taxpayer is Delinquent – HHSC has verified documentation showing collection attempts.
Harris County Hospital District	Sacred Oak Medical Center	Taxpayer is Delinquent – HHSC has verified documentation showing collection attempts.
Lubbock County Hospital District	Lubbock Heart and Surgical Center	Taxpayer was Delinquent, but a payment was subsequently received in Q1 of FFY21.
Travis County (Central Health Hospital District)	Arise Austin Medical Center	Taxpayer is Delinquent – HHSC has requested documentation of ongoing collection attempts.
Travis County (Central Health Hospital District)	Baylor Scott & White Medical Center - Pflugerville	New Facility – did not have sufficient data on which to base an assessment during FFY20.
Travis County (Central Health Hospital District)	Lake Travis ER LLC	New Facility – did not have sufficient data on which to base an assessment during FFY20.
Travis County (Central Health Hospital District)	The Hospital at Westlake Medical Center	Taxpayer is Delinquent – HHSC has requested documentation of ongoing collection attempts.
Williamson County	PAM Behavioral Health of Round Rock	New Facility – did not have sufficient data on which to base an assessment during FFY20.

2. In a response to round 2 of our questions concerning LPPFs, the State of Texas wrote that every LPPF that assessed mandatory payments on hospitals had at least one hospital that received less in Medicaid payments than it paid in tax. Can the State please explain why four of the LPPFs listed in Attachment B were assessed mandatory payments in which all the hospitals received Medicaid payments in an amount greater than or equal to their tax burdens (for Ellis, Nueces, Cherokee and McClennan Counties)?

State Response (9/29/2021): Texas understands the purpose of the attestation requested (No localities impose a tax where all hospitals paying the tax receive their total tax cost back in the form of Medicaid payments funded by the tax (including

localities that impose a tax on a single hospital)) to be in relation to CMS' expressed concerns that a hold harmless arrangement may exist. The state is providing our attestation that no hold harmless arrangement exists as described in section 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f). Texas has analyzed the data, as requested by CMS, and identified the four jurisdictions noted in this question. In Texas' Round 2 responses, Texas noted that Nueces and Cherokee counties had authority to operate an LPPF but were not actively operating one during the time period in question; therefore, the mandatory payments assessed to providers was $0. In Ellis and McClennan Counties, there was no correlation between the amount the hospitals paid in mandatory payments to the government entity and the amount the hospitals received in payments from the Medicaid program. Section 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f) do not prohibit all providers in a jurisdiction from receiving Medicaid payments that meet or exceed the amount paid by those providers as a mandatory payment to the government jurisdiction. HHSC reiterates its informed belief that there is clear evidence that no hold harmless arrangement exists.

3. Within Attachment B, in column J of the LPPF data tab, can the State of Texas please clarify the meaning of the column heading "Where LPPF Revenues are a Potential NFS Source"?

   State Response (9/29/2021): Column J is the sum of columns G, H, and I. In 2020, these three programs were the only ones that were supported via intergovernmental transfer funds that may have included funds derived from LPPFs. Therefore, Column J is "Total Medicaid Program Payments Where LPPF Revenues are a Potential NFS Source". Texas does not construct program payment methodologies where payments in programs have a 1:1 relationship between the source of the non-federal share and the payment amount received by the provider. Rather, most programs utilize a payment methodology that is entirely agnostic of the source of funds; therefore, it is impossible for Texas or any provider to say which specific non-federal share funds were used to support specific payments to providers, as all non-federal share funds are pooled and used to support the payment methodology designed by the state and approved by CMS.

4. The state provided a written assurance in response to a CMS request for an attestation relating to agreements that may be part of a hold harmless arrangement that would violate section 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f)(3). However, the attestation does not align with the request because it does not attest that no arrangement exists, through written agreements or otherwise, which involves participating hospitals transferring, redirecting, and/or redistributing (including through pooling arrangements) their payments supported by the tax to other Medicaid providers, directly or indirectly. Additionally, it does not provide an indication that the state obtained any necessary information from each LPPF-participating provider and/or the LPPFs, as needed, to support the state's attestation that no such arrangements exist.

   CMS remains concerned that agreements in place may be part of a hold harmless arrangement that would violate section 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f)(3). Please provide the previously requested information on the agreements and/or the requested attestation.

	State Response (9/29/2021): CMS and Texas are in agreement as to the importance of ongoing oversight and detailed analysis as to the permissibility of the non-federal share of Medicaid payments. The LPPF arrangements in Texas are designed within the parameters of permissible local health care-related taxes in that they are uniform, broad-based, and do not include a hold harmless arrangement whereby the local government administering the tax provides for any direct or indirect payment, offset, or waiver. CMS has required Texas to attest that there are no oral or written agreements between the local government entities and entities subject to the tax. Texas has done so based on discussions with the entities imposing the tax, as well as confidence in the local governments' compliance with the statutorily imposed requirements. In addition to such attestation, Texas has provided a monitoring plan for ongoing, comprehensive, and detailed oversight of the LPPF programs to ensure continued compliance with federal statute and regulations governing the non-federal share. The Texas legislature has provided resources, and Texas is progressing on the goal milestones that were submitted to CMS, including hiring a Director for Local Funds Monitoring who is building a team to perform this critical function. The monitoring team will have a primary directive of performing deep-dive analyses of LPPF arrangements to verify the permissibility of the local funds being used to finance the non-federal share of Medicaid payments, as required of the State Medicaid Agency. CMS has also requested that Texas require each local government to make a similar attestation. Texas is willing to incorporate a new certification for local governments that would be required during LPPF reporting. The potential certification would state: > I hereby certify that there are no agreements, whether written or oral, between this unit of local government and any entity subject to the mandatory assessment whereby an entity subject to the tax is held harmless as described under Social Security Act §1903(w)(4) and 42 C.F.R. §433.68(f)(3). We are hopeful that such certification will be part of the reporting process following the next reporting system update. The federal provider tax law CMS cites only gives CMS (and, consequently HHSC) authority to reject local funds where a tax is not broad based, is not uniform, or where the unit of government holds a taxpayer harmless from the tax; the law does not authorize CMS to deny state share funds based upon the existence or non-existence of agreements exclusively between private entities. As Texas has made clear in its responses, HHSC does not have regulatory authority over private agreements amongst non-governmental actors. HHSC requested CMS' feedback on what legal basis CMS relies on to require Texas to make such an attestation. CMS has been unable to provide a persuasive explanation for its interpretation of the law, nor did CMS provide specific feedback on what statutory or regulatory provision restricts Medicaid providers use of funds once earned by the provider. Texas made and stands by its attestation:

Texas attests that all units of government and the hospitals within their jurisdictions are in compliance with 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f). Texas attests the units of local government imposing a mandatory payment (i.e., Local Provider Participation Fund (LPPF)) do not provide for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly guarantees to hold taxpayers harmless for all or any portion of the tax amount. Texas attests that neither the state or any unit of local government within the state issue a payment directly or indirectly to any participating hospitals such that the hospital could compel an agreement from another hospital to transfer, redirect, and/or redistribute (including through pooling arrangements) payments supported by LPPF revenues.

CMS Response (10/18/2021): CMS remains concerned that agreements in place may be part of a hold harmless arrangement that would violate section 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f)(3). CMS refers the state to the original question above for the requested statutory and regulatory basis for requesting such information/the attestation. CMS is reiterating its previous request for information the agreements and/or for the requested attestation.

Additionally, recognizing that HHSC maintains that it does not have regulatory authority over private agreements amongst non-governmental actors, HHSC has previously acknowledged to CMS that it is aware of the referenced agreements. Please explain how the state became aware of the agreements and provide a description of how the arrangements work based on the HHSC's current understanding.

State Response (10/22/2021): In December of 2018, HHSC was made aware that private hospitals in at least one jurisdiction had orally agreed – exclusively amongst private entities and without the involvement of a taxing authority – to ensure that hospitals subject to the tax were "not unduly burdened" by the existence of an LPPF. HHSC received this information from a consultant for private hospital systems that did not specify either the jurisdiction in which these oral agreements or mutual understandings had taken place, nor did the private hospital consultant clearly describe what the parties had agreed to amongst themselves. HHSC called the then-Director of CMS' Financial Manamgent Group to notify CMS of this information and seek guidance. Shortly thereafter, HHSC received written approval of the LPPF structures in Dallas and Tarrant Counties from CMS, which Texas relied upon in accepting IGT from other jurisdictions' LPPFs subsequently.

In 2019, CMS and Texas became aware that a private consultant had conducted a presentation describing something the consultant described as "Community Benefit Payments." HHSC has explained to CMS in writing that it became aware of the presentation at the same time CMS did. As HHSC has already informed CMS, following this discovery, HHSC had two conversations with stakeholders to discuss CMS's position on written mitigation agreements. HHSC also had a phone call with

CMS, which was made at the request of stakeholders to find out CMS's position about such written agreements. The purpose of all of these conversations was to ensure both CMS and the stakeholders that HHSC is operating transparently.

Texas has explained to CMS in writing that we had no involvement with the types of arrangements described by the consultant, but that we believed the purported agreements would comply with 42 C.F.R. 433.68. We further stated:

> HHS OIG reviewed similar actions regarding the Missouri DSH program in 2003 and determined that "because the agreements were voluntary between the hospital provider and the MHA/MSC, and because there are no regulations precluding the arrangement, we are not making any recommendations for recovery of the pooled payments in excess of DSH limits." HHSC has reasonably relied on this opinion and current regulations to inform its oversight responsibility.

CMS has provided federal matching funds for DSRIP, UHRIP, and UC, all of which utilize LPPF-derived IGTs as a source of non-federal share.

Now, CMS is asking the same questions and requesting an attestation from HHSC about information that neither CMS nor Texas have authority to seek or consider.

Since the 2019 discovery described above, HHSC has not received any information from anyone that further identifies any details about any written or oral agreements that may exist among some providers in some jurisdictions, including any explicit written confirmation that they do exist at all.

HHSC has not reviewed, approved, or sanctioned any such agreements or arrangements, and does not intend to. However, HHSC will fully investigate the conduct of each governmental entity administering a LPPF and confirm that no governmental entity is engaged in a mitigation arrangement, as such circumstance would create a hold harmless under Social Security Act §1903(w)(4) and 42 C.F.R. §433.68(f)(3).

CMS continues to assert that the attestation from HHSC does not go far enough. On our call Tuesday, October 19, 2021, Texas specifically asked if other states had been asked to make such an attestation. The Acting Director of CMS' Financial Management Group replied that at least one other state had been asked to make a similar attestation, but confirmed that no state has made an attestation that CMS deems satisfactory. CMS fully understands the operation of the LPPF program in Texas, which is consistent with provider taxes that exist in many other states. HHSC may differ from many states in that it has been completely transparent with regard to the operation of its programs, including in December 2018 when HHSC immediately passed along new information to CMS.

There is no legal basis for CMS or HHSC to regulate agreements between non-governmental entities. CMS proposed amending its regulations to create a broader

scope of oversight in this arena, but failed to accomplish such an expansion. HHSC is invested in ensuring the Texas Medicaid population continues to receive services, and to do so, must ensure that Texas providers are paid for services provided to Medicaid patients. HHSC is committed to ensuring that the non-federal share of Medicaid payments comes from a permissible source. Provider taxes in a local jurisdiction are a permissible source so long as they are uniform, broad based, and the taxing entity does not hold a taxpayer harmless from the tax. As stewards of the non-federal share, HHSC has repeatedly asked CMS for a compelling legal basis for regulating agreements between private parties. CMS has not been able to produce that cite.

Texas requests that CMS provide the responses to the questions that we sought answers to on the October 19, 2021 call that CMS was unable to answer at the time. Specifically, please provide the following:

(1) Please identify any state(s) that have been required to submit a similar attestation prior to receiving a state directed payment program approval;

CMS Response (11/10/2021): Similar to Texas, CMS requested an attestation from one other state relating to a state directed payment financing arrangement involving possible redistribution of provider payments. Although the circumstances in Louisiana differ from Texas' LPPF arrangement, Louisiana submitted a state-direct payment proposal that generated questions surrounding the financing of the non-federal share of Medicaid payments, specifically relating to provider-related donations and the redistribution of Medicaid payments. CMS requested that Louisiana provide an attestation from their providers regarding these arrangements (see response to question two for more detail). While CMS was working with the state regarding its payment proposal, including the financing concerns, the state withdrew its proposal and it was not approved. Recently, CMS has engaged with Louisiana on a new payment proposal and CMS and the state are actively working with the state to ensure the non-federal share is permissible.

Missouri committed to CMS to end an apparent pooling arrangement relating to a hospital tax in which Medicaid payments appeared to be redistributed among private providers to hold provider harmless for the hospital tax. Subsequent to this commitment, Missouri submitted a proposed state-directed payment that appears to rely on similar financing arrangements. Recently, CMS has identified concerns with financing arrangement in conjunction with this payment proposal and CMS and the state are actively working to ensure the non-federal share financing meets all federal requirements.

State Response (11/15/2021): Thank you for this information. CMS' response indicates that the circumstances in Louisiana and Missouri are dissimilar to Texas' situation except that CMS is also refusing to approve their proposed programs. Based upon the statements above, we understand CMS to be indicating that Louisiana has not submitted completed attestations in writing that satisfy CMS' request, and Missouri has not been asked to submit an attestation at this time.

	Can CMS provide any written commitments or documents from the exchanges between CMS and either state where the state explicitly agrees with CMS' position that CMS has legal authority to demand attestations related to private business arrangements where no governmental entity is a party in order to achieve a program approval? If CMS has no documentation to this effect, can CMS explain in what way the comparison to these other states are relevant to Texas' situation? (2) If any state that has a provider tax was not asked to make such an attestation, please identify them and explain why they were not asked to make such an attestation; **CMS Response (11/10/2021)**: CMS has required that all states requesting approval of a state-directed payment cease arrangements that are financed by a health care-related tax for which we have knowledge of, or information suggesting that there may be, an arrangement whereby private providers agree to pool and redistribute Medicaid payments for the purposes of holding all providers harmless for the cost of the tax. We are currently working with these states to ensure compliance with federal Medicaid financing requirements. CMS does not request attestations from all states with a health care-related tax. However, CMS has not identified apparent hold harmless arrangements in all states with a health care-related tax. Despite numerous requests, Texas has not provided the information needed to ensure the LPPF arrangements used to fund the state directed payments meet federal requirements. With only very limited information from the state on the LPPF arrangements, CMS has relied on publicly available third-party materials[1] for more complete information about the arrangements. Texas has not denied that the information provided in those materials is an accurate description of how the LPPFs operate in Texas. As previously requested in our regular meetings and via email exchanges, we request the state respond to the five items below in writing. We are seeking a clearer understanding of the specifics of the redistribution aspect of the LPPF arrangements, and for copies of any agreements that might be in place. Although the state has explicitly acknowledged the agreements exist among providers, it has indicated to us that it "has not reviewed, approved, or sanctioned any such agreements or arrangements, and does not intend to." The statute and implementing regulations prohibit hold harmless arrangements without consideration of whether the state has "reviewed, approved or sanctioned" them. Based on the available information, it appears that LPPF-participating parties (and the state, due to its knowledge of the existence of the LPPF arrangements) reasonably expect that taxpaying hospitals are held harmless for all or a portion of the tax. Further, Texas has not disputed the mechanics of the arrangement described in the third-party materials. We have repeatedly provided the state an opportunity to demonstrate that the hold harmless arrangements described are not in place or have ended, including through attestations from the state or participating providers. These attestations

[1] https://lonestarhfma.org/wp-content/uploads/2015/06/170801-David-Salsberry.pdf

are not specifically required by law, but we have offered them as a way for CMS and the state to avoid the more resource-intensive, back-end investigations into exactly how the LPPF arrangements work in each locality, which otherwise could be necessary in connection with deferrals or disallowances of FFP. So far, the state has only offered us a limited assurance that covers only units of government and does not cover any private providers that participate in LPPF arrangements, including those that receive Medicaid payments. If the hold harmless arrangements described above do not exist or if Texas has already taken measures to end those arrangements, please provide the following information to demonstrate that the state's non-federal share sources comply with section 1903(w)(4) of the Social Security Act and implementing regulations in 42 CFR 433.68(f)(3):

A. A comprehensive description of how the LPPF arrangements work, including at the provider level.
B. Copies of mitigation agreements or similar agreements in place between or among LPPF-participating providers and/or the LPPF and a complete description of how the LPPF mitigation arrangements work, including at the provider level.
C. As an alternative to providing the agreements in #2, attestations from each participating provider or from the state (attesting on behalf of each provider) that the providers do not participate in arrangements, through written agreements or otherwise (including non-written agreements or understandings that result in reasonable expectations for participating parties), which involve participating providers transferring, redirecting, redistributing (irrespective of state or local government involvement) Medicaid or other payments to other providers, directly or indirectly (irrespective of whether the state or unit of local governments are compelling or sanctioning provider participation).
D. If all participating providers or the state are able to provide the attestation(s) in #3, a comprehensive description of the process used by the state and providers to ensure the accuracy of the attestation(s) that the arrangements described in #3 have either stopped or were never in effect.
E. Confirmation that no locality, including Ellis and McClennan Counties, imposes a health care-related tax in which all taxpaying hospitals receive at least their total tax cost back in the form of Medicaid payments or other payments.

State Response (11/15/2021): CMS and Texas have a fundamental disagreement on the authority that 1903(w) confers on CMS (and by extension Texas) to examine and consider private business arrangements that may or may not exist in determining the permissibility of the use of funds as non-federal share in the Medicaid program. Despite the fact that LPPFs have been authorized and in use in the Texas Medicaid program since 2013, and that CMS has repeatedly approved programs that utilize LPPF-derived funds as a method of finance, CMS now seeks to coerce Texas into adopting CMS' position and serving as its agent in pursuing an unauthorized regulatory agenda by threatening deferrals or disallowances and withholding program approvals. CMS overreaches its authority and is threatening the fabric and stability

	of the Texas Medicaid program in an effort to renegotiate terms and conditions that CMS attempted to insert into the 1115 Waiver that was approved in January 2021 (and that Texas rejected due to the lack of legal authority for such Terms and Conditions). The discussion between CMS and Texas on CMS' unreasonable interpretation of 1903(w) has been ongoing for almost 3 years – and CMS has approved multiple programs in Texas during that time period. There is no reason for CMS to adopt a new position that the programs that utilize LPPF-derived funds in Texas are not approvable. CMS agreed on April 10, 2019 (more than 20 months after the date of the cited presentation), that it is accurate "that CMS is aware that there may be arrangements out there among providers that you do not particularly like, but that you do not have statutory authority to address, which would include these types of mitigation agreements." (See Attachment A). Can CMS explain on what legal or regulatory basis the agency now believes that it does have this authority, even though the statutes and regulations have not changed? As the state indicated to CMS in writing in August 2019, the state has been told that some sorts of arrangements between private entities exist, but the state seeks no involvement and has not been involved in any such arrangements…**because it does not have the authority to do so.** (See Attachment B)**.** Texas has repeatedly explained to CMS why CMS (and Texas) do not have the authority to consider, regulate, or prohibit the use of funds in the Medicaid program as a result of private business relationships where no governmental entity is a party. Additionally, can CMS confirm that in response to pre-print question 35(c), CMS has only approved programs where a state has answered the question and affirmatively stated that no arrangements exist "amongst healthcare providers and/or related entities"? If not, can CMS provide a comprehensive list of the answers that were provided, by state, and any follow up questions that were sent to a state related to their response to that question, for all programs that have been approved since that question was added to the pre-print template? With respect to Ellis and McClennan counties, there is no prohibition on all providers subject to a provider tax receiving Medicaid payments that meet or exceed the amount that the taxpayer paid. Rather, 42 CFR 433.68(f) describes three conditions in which a taxpayer will be considered to be held harmless. First, the state or unit of government imposing the tax must provide a **"direct or indirect non-Medicaid payment to those providers or others paying the tax and the payment amount is positively correlated to… the tax amount."** (emphasis added). Second, the regulation speaks to a condition where the "**Medicaid payment to the taxpayer varies based on the tax amount, including where Medicaid payment is conditional on receipt of the tax amount**." (emphasis added). As previously described, no payment methodology used by the state for any program in which local governments have transferred funds derived from LPPF revenues considers the source of the revenues. Third, the regulation speaks to a condition where "[**t]he State (or other unit of government imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless…"** (emphasis added). All LPPFs in Texas are operated by local governments who cannot provide for a direct guarantee with respect to Medicaid payments as

	HHSC is the sole Medicaid agency for Texas, and local governments are not in a position to direct Medicaid payments or Medicaid payment methodologies used in SDPs. Further, no direct guarantee exists as the state's payment methodologies are not related to the source of funds. The regulation provides for a two-pronged test to determine if there's an indirect guarantee, which considers whether the amount taxed exceeds 6 percent. If the tax amount applied is 6 percent of net patient revenue or less, the tax is permissible. In Texas, all LPPFs by state law are prohibited from assessing mandatory payments that exceed 6 percent, therefore no indirect guarantee exists. Can CMS please identify where in the statute or regulation all taxpayers are prohibited from receiving their full tax amount in the form of a Medicaid payment if the payments are not correlated to the paid tax amount? Has CMS required all states or jurisdictions where a provider tax is in place to conduct an analysis to examine whether the providers are all receiving their paid tax amounts in the form of Medicaid payments? If not, why not? If the matter of whether the Social Security Act conveys to CMS (or Texas) the authority to consider fully-private business arrangements in restricting Medicaid funds derived from a provider tax is resolved in accordance with Texas' stated understanding of the law, does CMS agree that CMS would not have the authority to withhold approval of a program proposal due to the possibility that some such private business relationships might exist? (3) Please provide a template or language that has been used by another state to resolve CMS' concerns related to a similar matter; **CMS Response (11/10/2021)**: As we indicated in response to question one, no state with outstanding financing issues has included an attestation as a condition of approval for a state-directed payment because we have not reached the approval stage with these states. For example, we requested Louisiana provide such an attestation during the review of its state-directed payment, but Louisiana ended up withdrawing their proposal and it was not approved. Louisiana's situation was similar, but not identical, to Texas's. Instead of a hold harmless arrangement relating to health care-related taxes, the potential hold harmless arrangement in Louisiana related to provider-related donations. Therefore, we do not believe that the specific language requested from Lousiana would directly apply in Texas. For purposes of transparency, the language of Louisiana's proposed attestation, which was still in open discussion between the state and CMS, read as follows, "(Name of Entity/Facility) through the authorized signatory below, hereby certifies that it has no agreements (written or otherwise), or agreements under active consideration, with any hospital provider that would receive Medicaid reimbursement as a result of the directed payment program that would present the possibility of a transfer of value between a public and a private entity for the purposes of providing the state match for the direct payment program to LDH through IGTs." We intend to request similar language in conjunction with any state directed payment with similar provider payment redistribution/hold

harmless concerns during the payment review, adapting the language as necessary to fit the circumstances.

State Response (11/15/2021): Texas appreciates the information. Texas agrees that the specific language requested from Louisiana would not apply in Texas. Further, since there is no attestation template that has ever actually been used by CMS with another state, it appears that this is a new requirement that CMS is imposing on certain states for reasons that are arbitrary or entirely pretextual.

Given that CMS withdrew the proposed rule that would have expanded the circumstances in which a direct guarantee could have been found to exist, what is CMS's legal authority for finding a direct guarantee when a governmental entity is not a party to the arrangement?[2] Texas is trying but unable to reconcile the contradiction that CMS could approve "the comprehensive hospital increase reimbursement program (CHIRP) for SFY 2022 to reflect only the uniform hospital rate increase program (UHRIP) payment amounts that were approved in UHRIP for SFY 2021" in August 2021 but now requires modifications to the method of finance when neither the facts nor the law have changed.

(1) Please provide the statutory basis for restricting providers from utilizing Medicaid payments that they have duly earned (either based upon performance or an adjudicated claim) after it has been received by the provider;

CMS Response (11/10/2021): CMS is not imposing new restrictions on how providers utilize Medicaid payments. Providers are free to utilize their Medicaid payments in any manner consistent with federal requirements. However, as CMS has repeatedly explained to Texas, if there is in effect a hold harmless practice with regard to a health care-related tax, as specified by Section 1903(w)(1)(A)(iii) of the Social Security Act, CMS is statutorily obligated to reduce the state's medical assistance expenditures by the amount of such a tax prior to providing FFP to the state.

Medicaid regulations at 42 CFR 433.68(f)(3) state that a hold harmless arrangement exists where a state imposing a health care-related tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount. We recognize that the statute clearly permits health care-related taxes and we support states' adoption of these financing strategies. However, the taxes must be imposed in a manner consistent with applicable federal statute and regulations and cannot include a direct or indirect hold harmless arrangement. In the preamble to the 2008 final rule amending this provision, CMS wrote that, "[a] direct guarantee will be

[2] Even if CMS had finalized MFAR and attempted to expand the circumstances in which a direct guarantee could have been found to exist, CMS's authority would have been limited by Social Security Act § 1903(w)(4), which does not permit CMS to regulate private business arrangements.

found when a State payment is made available to a taxpayer or a party related to the taxpayer in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax." 73 FR 9685, 9695 (Feb. 22, 2008) (confirming proposed rule preamble statement in 72 FR 13726, 13730 (Mar. 23, 2007)).

As CMS further explained in the same preamble, we used the term "reasonable expectation" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless." 73 FR at 9694. Therefore, hold harmless arrangements are not always overtly established through state law, but can be based instead only on reasonable expectations of certain actions among participating entities.

The state has indicated it is aware of the existence of agreements among at least some LPPF-participating providers. The state has not provided any information to CMS that refutes the third-party description as representative of the LPPF arrangement. By its own statements, dating back to December 2018, the state has been aware that agreements among providers relating to the LPPF may exist. Further, the state acknowledged that it obtained this information through direct conversations with a consultant and through CMS providing the third-party information described above. In the LPPF arrangements, all parties appear to have a reasonable expectation that the taxpaying hospitals, whether directly through their Medicaid payments made by the state (including through proposed CHIRP, RAPPS and TIPPS state directed payments) or due to the availability of the redistributed payments from other taxpaying hospitals, are held harmless for all or a portion of their tax costs. This appears to be a hold harmless arrangement described in section 1903(w)(4)(C) of the Act and 42 CFR 433.68(f)(3).

State Response (11/15/2021): CMS has indicated that it is relying on the language in the 2008 rule preamble relating to a provider's "reasonable expectation." However, neither 1903(w) of the Social Security Act nor 42 CFR 433.68 contain the term "reasonable expectation" to define or refine the evaluation of whether a direct guarantee exists. Notably, CMS' guidance in the final rule's preamble provides, "A direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments). A direct guarantee does not need to be an explicit promise or assurance of payment. **Instead, the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy** (73 Fed. Reg. 9694 (emphasis added). CMS has been unable to produce a state statute, regulation, or policy that would implicate a guarantee in violation of 42 C.F.R. 433.68(f)(3) because none exist.

Can CMS please specify whether, as described in 73 Fed. Reg. 9694, it has determined there is a provision for payment by Texas statute, regulation, or policy? If CMS cannot identify whether there is a provision for payment by State statute, regulation, or policy, can CMS

please explain under what law Congress has authorized CMS to regulate private business relationships? If no such law exists, can CMS please explain how CMS has chosen to assume powers and duties that have not been conferred upon CMS by Congress?

(2) Please provide clarity on CMS' statements about another state in a "similar situation" to Texas, including a description of what CMS believes constitutes a "similar situation"; and

CMS Response (11/10/2021): Please see our response to question one.

State Response (11/15/2021): Texas understands from CMS' response to question one that there is no state in a similar situation despite CMS' representations as CMS clearly explained that the situations are factually disparate.

(3) Please provide an estimate on when Texas can expect a response to our September 7, 2021 letter accepting CMS' offer to extend DSRIP for one year, continue UHRIP and QIPP on a temporary basis, and continue to work with Texas to resolve any matters of concern on the 5 pending directed-payment programs.

CMS Response (11/10/2021): Texas's September 7, 2021 letter did not accept either option set forth in CMS's August 13, 2021 letter providing specific modifications Texas could make to its SDPs to make them approvable. As we have explained in several of our meetings with the state, there was no agreement on a path forward based on Texas's September 7 letter. Accordingly, we have continued our work with the state on information the state can provide and changes the state can make to its proposed SDPs to demonstrate they are approvable. We have also had discussions since September 7 with the state about an alternative mutually agreeable path forward. We also anticipate sending a letter to the state soon, which will further discuss a path forward.

State Response (11/15/2021): Texas looks forward to receiving the letter described above as Texas has not yet been given any meaningful details by CMS about the potential pathway that CMS references. In the conversations we have had to date, CMS has indicated orally, but never in writing, that there are "other vehicles" that CMS is willing to discuss for Texas, but CMS has not provided any details on what these "vehicles" would be, when they would start, what the amount would be, and how the budget neutrality terms would be altered to ensure the long-term stability Texas has sought for the Medicaid providers who have been impacted by COVID-19. Nor has CMS explained why these other vehicles, which presumably could not be implemented until Fiscal Year 2023 at the earliest, prohibit CMS from moving forward with resolving and approving the programs proposed by Texas.

Texas does understand from recent conversations that CMS has had with Texas and with interested Texas stakeholders that CMS has altered the position represented by CMS in the August 13, 2021 letter to Texas. Texas understands that CMS is now indicating that the offer

	to extend DSRIP for one-year is only available to Texas if Texas exclusively selects Option 1 as presented in CMS' August 13, 2021 letter and withdraws its requests for approval of TIPPS, RAPPS, and DPP for BHS. Can CMS please confirm that this is correct? Texas also understands that CMS has determined that it cannot approve any program that is financed using revenues derived from LPPFs – including DSRIP and UHRIP – even though CMS did not include any indication that modifications to the method of finance for DSRIP and UHRIP would be required in the August 13, 2021 letter. Texas further understands that CMS believes that immediate actions to prohibit any private business arrangement that may or may not exist would be required before CMS is willing to approve any program – SDP or otherwise. Can CMS please confirm that this is correct? CMS has indicated that there is no objection to the existence or use of LPPF-derived funds, merely to the "LPPF arrangements." But the supposed "arrangements" to which CMS refers are not included or authorized by the state statutes that authorize LPPFs in Texas. CMS has made vague references to potential structural remedies that might be available, but Texas has indicated to CMS that LPPFs are authorized by state law and the Texas Legislature's next regularly-scheduled session is not until 2023. However, CMS has stated in spite of this timing, CMS will require actions by Texas immediately. Additionally, CMS has threatened to issue deferrals or disallowances of funds if Texas does not take the immediate actions described previously. Can CMS please confirm that this is correct? Texas assumes the details about the potential future pathway, including any requirements related to the method of finance for these vehicles, will be included in the forthcoming CMS letter referenced above. If any of the items of understanding that have been identified in the paragraphs above are inaccurate, Texas requests that CMS provide clarity in the anticipated letter. Texas requests that the letter be provided to Texas no later than November 20, 2021. We hope that Texas can be treated equitably with all other states as we continue to resolve any outstanding matters that remain after this round of responses. Texas providers are continuing to provide services to Medicaid patients, despite a significant delay in payments as CMS attempts to rehash this issue, but we cannot expect them to continue to do so indefinitely.

Texas Budget Neutrality (BN) Implications Questions on State Directed Payments (SDPs)

- Texas has asked about the budget neutrality (BN) implications for the next year of the demonstration.
- CMS' offer to extend DSRIP is intended to help provide stability over the next year while we continue to work on the SDPs and other approaches to secure the safety net.
- Under current BN policy, the DSRIP expenditures would be authorized as a cost not otherwise matchable (CNOM) and would be reflected on the "with waiver (WW)" side of

budget neutrality for the coming year. In applying the rebasing policy, as articulated in STC 62, CNOM are not included in the without waiver (WOW) baseline.

- The state has adequate savings to absorb these additional DSRIP expenditures for the next demonstration year.
- CMS recognizes the importance of and shares Texas's commitment to maintaining a sustainable approach to safety net hospital reimbursement. The one-year DSRIP extension provides an opportunity for CMS and Texas to continue to work toward a more sustainable, equitable, and high quality safety net.

TX-CMS Call on 8/18/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Courtney Caruthers
Gary Young	Kate Hendrix	Victoria Grady
Kathi Montalbano	Dara Nix	
Brittani Bilse	Sarah Diseker	
Andy Vasquez	April Ferrino	
Rachel Butler	M Ghasemi	
Trey Wood	Stephanie Tourk	

CMS Attendance

Daniel Tsai	Layla Fraser	Jennifer Clark	Tom Caughey
Judith Cash	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
John Giles	Allison Weaver	Charlie Arnold	Carrie Smith
Laura Snyder	Elizabeth Clark	Jonathan Endelman	Norina McAuliffe
Juliet Kuhn	Christopher Thompson	Andrew Badaracco	Michelle Beasley
Eli Greenfield	Jeremy Silanskis	Richard Cuno	Daria Romanov
Diona Kristian	Jocelyn Velez	Deborah McClure	James Burns
Shamberkia Wise	Tamara Sampson	Jennifer Maslowski	Amy Gentile
Teresa DeCaro	Rebecca Burch Mack	Mara Siler-Price	Anna Bonelli

Opening remarks from Daniel Tsai, Director, Center for Medicaid and CHIP Services (CMCS)

- CMS wants to work with state to find a long-term path that includes state directed payments (SDPs) and other vehicles (via 1115 or other).
- State directed payments (SDPs) are not approvable in current form. Aggregate total dollar amount for the proposed SDP is major concern. The state will still not be able to proceed with using SDPs solely for the proposed $7B in funding.
- There are modifications that the state can make to the SDPs to satisfy the statutory and regulatory requirements, and the CMS team is prepared to discuss these technical issues with the state further.
- CMS' appreciates that there are practical issues on the ground (e.g., sheer number of hospitals in Texas and range of underlying financing arrangements).
- If agree to extend DSRIP as outlined in CMS' August 13 letter to the state, the state and CMS should begin taking actions associated with 1115 amendments right away.
- Suggest having different tracks – one that moves to quickly resolve the DSRIP extension and another that works on the SDPs and other funding mechanisms over coming months.

Opening remarks from Stephanie Stephens, Texas Medicaid Director

- Texas needs to better understand CMS' concerns and what modifications we can make to address them. State would like to have conversations about the SDP technical fixes in the short-term.

- The state has not yet decided about the options outlined nor the DSRIP extension proposal in the August 13 letter to the state.
- The state understands CMS' concern about the total aggregate amount of SDP funding. However, do not know how to adjust aggregate amount until understand CMS' concerns with the payment structures since proposed SDPs are based on certain approaches and assumptions.

Judith Cash (Acting Deputy Director, CMCS) and Alissa DeBoy (Director, Disabled and Elderly Health Programs Group, CMCS) expressed their commitment to working with state and to provide specific details on CMS' concerns.

John Giles (Director, Division of Managed Care Policy, CMCS) expressed that he would talk through CMS' technical concerns, by preprint, should the state want to pursue Option 2 of the August 13 letter and makes modifications to the proposed SDPs for SFY 2022.

For the Quality Incentive Payment Program (QIPP), John remarked that the reconciliation threshold requirement in Component 1 has been a concern historically in CMS' QIPP reviews and noted that this policy was discussed in CMS' January 2021 SMDL on SDPs and that the SFY 2021 QIPP approval letter included language that CMS expected that the state remove this construct for future rating periods. Victoria Grady (Texas) noted that the state anticipates that the reconciliation would be triggered for SFY 2021, which informed their thinking for SFY 2022. She noted that a QIPP stakeholder workgroup was formed and believes the state will be able to better address this for SFY 2023. John expressed that it is CMS' expectation that state remove these reconciliation requirements going forward, noting that this is consistent with CMS' pass through payment policy and support the goal of ensuring payments are built on utilizations and delivery of services.

Rory Howe (Acting Director, Financial Management Group, CMCS) and his staff highlighted two areas of concerns related to financing of the non-federal share. This first area of concern relates to IGTs that may utilize bond financing. While there is general agreement that localities can utilize bonds, the concern lies when participating providers are involved in the financing of the bonds since it could be perceived as provider related donations. CMS needs to understand the state's oversight plan. Victoria Grady noted that the legislature just allocated funds to build out a team (15 people) for this purpose. The oversight plan is not yet developed since this team is just being formed but the state will be happy to share it once completed.

The second area of concern discussed specific state financing was relayed to locality taxes and LPPFs. Rory indicated there has been a lot of back and forth to-date on this issue with the state and CMS does not yet have sufficient information from the state to decide of permissibility. Specifically, CMS needs to better understand the arrangement in place and the state's oversight of these arrangement to in order assess if there are hold harmless arrangements in place. Other issues need to understand include if any participating districts have only one hospital and for LPPFs that are operated by local governments, making sure that they are not taxing hospital outside of their local jurisdiction.

Elizabeth Clark (Director, Division of Quality and Health Outcomes, CMCS) and her staff discussed CMS' concerns with the evaluation plans across the SDP proposals. Specific concerns discussed included not being able to isolate the effects and attribute results to an individual SDP proposal. The state indicated that they are working with their EQRO to develop an attribution model. CMS also discussed the concern

of the evaluation measures not be limited to the Medicaid managed care population and needing baseline statistics.

The following next steps were discussed:

- Setup calls every 2 days between CMS and state
- CMS to share a document that summarizes technical concerns with SDPs
- CMS send additional questions on state financing
- CMS and state to have future conversation on Option 1 from CMS' August 13 letter to understand budget neutrality impact for the 1115 waiver

TX-CMS Call on 8/20/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Courtney Caruthers
Gary Young	Kate Hendrix	Victoria Grady
Kathi Montalbano	Dara Nix	A Campbell
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	April Ferrino	Evan Dial
Rachel Butler	Michael Ghasemi	Daniel Dillon
Trey Wood	Stephanie Tourk	Karen Ray

CMS Attendance

Daniel Tsai	Layla Fraser	Jennifer Clark	Tom Caughey
Judith Cash	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
John Giles	Allison Weaver	Charlie Arnold	Carrie Smith
Laura Snyder	Elizabeth Clark	Jonathan Endelman	Norina McAuliffe
Juliet Kuhn	Christopher Thompson	Andrew Badaracco	Michelle Beasley
Eli Greenfield	Jeremy Silanskis	Richard Cuno	Daria Romanov
Diona Kristian	Jocelyn Velez	Deborah McClure	James Burns
Shamberkia Wise	Tamara Sampson	Jennifer Maslowski	Amy Gentile
Teresa DeCaro	Rebecca Burch Mack	Mara Siler-Price	Angela Garner

Stephanie – Texas's priority would be discussing the aggregate amount and actuarial soundness concerns. Want to understand if there are methodological concerns and whether the concern is across programs or one specific SDP in particular.

- Judith – As Dan outlined on our last call, overall premise is that the total amount needs to be less than what was previously proposed. John Giles can speak to the specific concerns.
- John – Concern comes from overall aggregate amount of SDPs that is being represented here. For some perspective, CMS has never approved SDPs at this size so would be precedent setting. And it is the largest year over year increase we have ever seen.
    - OACT is not on call today and they have not finalized review of capitation rates. However, they have shared their overarching concern with the aggregate increase in dollars would be flowing through managed care capitation rates from one year to the next. If the rates were reasonable and appropriate last year, why would the rates be actuarially sound for this year with new $3B worth of SDPs but without any new populations and services? Substantial and large increase in dollars flowing through managed care.
    - When looking at it at aggregate increase across rates cells, it may be difficult for OACT to find the rates actuarially sound.
- Trey – we have changed methodologies, so wouldn't the actuaries take this into account?

- John – setting aside methodology changes, all SDPs must flow through capitation rates. Year over year magnitude in capitation rates is significant.
- Trey – are there federal statute or regulations that can point to? Would request to have actuaries on next call.
- Stephanie – Want to ask again, are there any methodological concerns with any specific SDPs?

Judith – Think it would be helpful to walk through document CMS provided that outlined our remaining concerns with each SDP. John will do that.

John – Since spoke about QIPP on last call, any remaining questions on reconciliation threshold discussion?

- Victoria – would CMS consider allowing a reduced % for this year and then taking it out for next year? Is there an openness to that? Yes that is an option based on Option 2 of Aug 13 letter to state.
- John – Are there questions pertaining to performance needing to be based on year over year improvements?
- Stephanie – would like a place where quality experts on both sides can come together.
- John – this concern is based on the OIG audit findings. Also talked through eval plan concerns on last call.

John – on CHIRP, we will coordinate on finding time for actuaries on both sides to connect. On reimbursement level analysis, missing the ACR analysis for hospitals only participating in UHRIP only. Looking for hospital data regardless of component that the provider qualifies for.

- Victoria – 24 hospitals that meet that data. We have looked at ACR methodology that has been used in other states (like CA). Is this part of the aggregate concern? Know as get closer to 100% of the commercial rate, get more concerned. State looks at reasonableness as a class, not as a provider since more of indicator of market.
- John – There is a lot of complexity here because analysis is by provider class and SDA. Having the remaining data would help us further the discussion with Texas.

John – On TIPPS, reconciliation threshold is same concern across all proposals. For TIPPS and BHS, need to make sure payments are linked to performance at the provider level for Medicaid managed care benes only. Payments made under SDPs need to be on performance attributed to Medicaid managed care benes.

- Stephanie – on quality side, want to be sure CMS understands why we proposed what we did and the reasons for doing it that way vs not. Want opportunity to have this dialogue. On evaluation plan, state does feel like what they have provided is sufficient. Want to understand exactly what CMS is looking. On attribution question, there will always be crossover in attribution between proposals.

John – RAPPS and BHS, similar issues across. Want to Clarify that specific concern for payment (vs evaluation purposes) is that numerator needs to be just Medicaid managed care beneficiaries. Payment needs to be tied to provider's performance serving Medicaid managed care benes only.

TX-CMS Call on 8/20/21 Notes

Rory – Outline two area of concerns related to financing of the non-federal share.

- First – IGTs sourced by bonds. Based on what have heard, no indication from state that providers are purchasing bonds. However, concern arises if/when providers purchase these bonds as it could be perceived as provider related donation. CMS is looking for confirmation that this isn't happening and oversight plan on a prospective basis. How state will properly engage municipalities. Appreciate that the state is setting up new oversight group.
    - Victoria – Would a government entity have a list of those who purchases bonds (don't know since we at HSSC don't issue bonds)?
    - Rory – this is not a common financing mechanism which is why we're asking these questions. CMS could provide language that state could use when reaching out to these entities in the state. An appropriate response from an entity could possibly be that they at an arm's length and don't know who is investing – just part on normal routine business.
- Second - Locality taxes/LPPFs. Primary concern is to make sure no hold harmless arrangements. Few areas of concern:
    - Provider/localities redirecting Medicaid payments after payments were made? We know these arrangements exist now. Need some form of assurance from state and hospitals that these hold harmless arrangements are not in place. May be an area for follow-up conversation.
    - Victoria - Kristin Fan (when she was in her former role at CMS) provided written guidance that CMS didn't have concerns so why the change? Would want policy attorneys on call (not outside counsel) for next conversation.
    - Rory – CMS also wants an assurance across board that localities meet the requirements since not all localities implement taxes the same way. For smaller localities, concern if just taxing one hospital and then just getting money back. This would clearly be a hold harmless arrangement.
        - Victoria – can provide assurance that this is not happening. State has been collecting this data since 2019 so do have this type of reporting/information.
        - Rory – Other concern is localities imposing taxes outside of their jurisdiction. Would want assurance that this is not happening.

Judith – Budget neutrality question. Good to remind ourselves why we need to talk about BN. Anticipated approved SDPs were written into 1115 demonstration, so there is an 1115 implication but approval of SDPs are outside of demo. This is why we proposed the DSRIP extension for short term stability, since recognized state might not have full SDP amounts for this year. CMS does not think there is a BN issue.

- Stephanie - Texas is aware of offer and assessing that separately.
- Judith - CMS wants to make sure we can work with you in a timely manner on the 1115 actions.
- Trey – what about long-term BN? Understand that in the short-term would be able to absorb any offsets but what about the long-term?
- Michael – interested in exploring BN opportunities that are not tied to SDP approvals, to ensure budget stability. BN approaches and how we can adapt to different scenarios.
- Judith – happy to have the conversation. Might want to have it outside of these SDP conversations since that seems to be the priority in the immediate.

TX-CMS Call on 8/20/21 Notes

Stephanie – For next week's calls, noted 3 topics: actuarial soundness, quality, financing of non-federal share. Highest priority is on actuarial soundness conversation – can we prioritize that for Tues? Combine that with quality conversation for Tuesday and then have non-NFS conversation for Thursday.

- Prior to our next call, state may send some feedback in writing to CMS based on what CMS provided for today's meeting.

TX-CMS Call on 8/24/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	April Ferrino	Evan Dial
Rachel Butler	Michael Ghasemi	Erin Cibrone
Trey Wood	Stephanie Tourk	N. Boston
Joelle Jung	Emily Zalkosky	Amber?

CMS Attendance

Daniel Tsai	Layla Fraser	Jennifer Clark	Tom Caughey
Judith Cash	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
John Giles	Allison Weaver	Charlie Arnold	Carrie Smith
Laura Snyder	Elizabeth Clark	Jonathan Endelman	Norina McAuliffe
Juliet Kuhn	Christopher Thompson	Andrew Badaracco	Michelle Beasley
Eli Greenfield	Jeremy Silanskis	Richard Cuno	Daria Romanov
Diona Kristian	Jocelyn Velez	Deborah McClure	James Burns
Shamberkia Wise	Tamara Sampson	Jennifer Maslowski	Amy Gentile
Teresa DeCaro	Rebecca Burch Mack	Mara Siler-Price	Angela Garner
Chris Truffer	Tristan Cope	Paul Spitalnic	

Judith – two topics of conversation today: actuarial concerns and quality concerns on the SFY 2022 state directed payments (SDPs). In attendance from OACT is CMS' Chief Actuary: Paul Spitalnic, and from his team: Chris Truffer and Tristan Cope.

John – before get started, just want to reiterate data request regarding the reimbursement analysis that was discussed on Friday. ACR analysis for hospitals only participating in UHRIP – looking for data by hospital. Any questions from state?

- Victoria – 17 hospitals fall into category. Don't think will have this by tomorrow. But for tomorrow will have aggregate analysis by class (UHRIP only hospitals) and all hospitals. When we send this tomorrow, will also be sending some written questions to CMS as well.

Rachel Butler, Chief Actuary, HHSC – also on phone is Evan Dial. His company does the actuarial capitation rate setting for Texas Medicaid.

- Actuarial soundness seems to be a concern from CMS. On July 16th, Texas submitted SFY 22 capitation rate reports and outlined basis for SDPs and factors that would support rates. As always, actuaries provide opinion on reasonableness and appropriateness of rates using actuarial soundness principles. Since actuarial soundness principles are developed for rate setting by insurance companies, and not on reasonableness of provider rates, would like to hear from OACT on analysis performed and practices and principles being applied here.

Chris Truffer – There is a whole host of guidance and regulations around capitation rate setting. Make sure actuary doing their work professionally and properly. Large part of actuarial soundness is ensuring that the costs being factored in are reasonable and appropriate. There have been instances (not necessarily TX) where things are being built into rates and the reasoning for including those things in rates has been questioned.

- OACT also has a role in reviewing directed payment preprints. Concern (have voiced these in the past with TX) around cost associated with these preprints and payments to providers. Considerable amount of money in these preprints, particularly for hospitals.

Paul – Understand that questions to date have been around trying to understand the rates. Want a full understanding of what is happening with the rates and at the provider level. Chris, is that right that we're just working to understand lay of land?

- Chris – Yes, assessing impact of these programs on the provider payment rates. Premature to offer a conclusion.

Victoria – Want to differentiate between actuarial soundness of capitation rates and assessing provider rates to be reasonableness, appropriate, attainable (hospitals). Concern is on the latter, is that correct?

- Chris – yes, that is fair. Primary concern is the resulting provider payment rates.

Victoria – Regarding the assessment of reasonableness – would you contemplate a benchmark to Medicare and Commercial rates? Do you agree those are appropriate comparators?

- Chris – yes, we consider the rates of other payers. Acknowledge that there are underlying factors for different payors, also try to look at Medicaid FFS.

Victoria – Because there are 650 hospitals in TX, we look at hospital classes and not individual hospital. In your analysis, do you look at class vs hospital, since there would be variation by individual hospital?

- Chris – yes, we look across classes. If greater variation across providers (across or within), or if provider rates go higher or lower, would probably raise questions about variation. Obviously don't look at negotiation of every single provider.

Victoria – two other comments want to share: 1) 4% Medicaid expenditures ibn Texas are delivered in the FFS program. FFS schedule is not often leveraged b/c most clients are not served in FFS. 2) In making decisions for preprints, we considered underlying market changes. Know that CMS looks at changes year over year. For Texas, year over year dynamics are considerably different given movement away from DSRIP.

Rachel, Trey, state actuaries – No further questions.

Judith – Now turn to quality discussion.

Liz Clark – start conversation on evaluation plan, specifically attribution.

Gary – our team also has questions for CMS outside of the eval plan.

Jennifer Maslowski – Want to continue conversation from last week about being unable to isolate impact of SDPs using the evaluation measures. Texas has said that the SDPs reinforce each other will be

implemented at same time and unable to limit to just Medicaid managed care beneficiaries. It's okay to have evaluation measures that are same across the proposals – the state must be able to provide results that are specific to each SDP.

- Texas could have one evaluation plan that covers multiple SDPs but need to be able to attribute to the provider level. CA is an example of a state that has done this.

Andy Vasquez – There is difficulty in trying to isolate one SDP in the midst of large Medicaid program. Would be interested in seeing CA example. Glad to hear that there can be overall in evaluation measures across SDPs. Important for aligning measures for VBP purposes. Trying to use all levers available to us. Question for CMS: with QIPP, it is just nursing facilities for the provider group. Feel like this program is standalone. Does CMS agree?

- Jen – Yes, different population and provider pool. What also makes it more unique too is that its VBP arrangement.
- Andy – Want to be sure to clarify when we talk about "attribution" – attribution of program/SDP vs. provider/bene level. Ask to keep that in mind during discussion.
- Jen – yes, RAPPS and QIPP is where we have the provider-level attribution concerns. Not okay with QIPP model b/c still have concerns with attribution at provider-level.

Emily Sentilles – specific to evaluation, measures that we included were CMS recommended measures, such as the Medicaid core set measures. Those specific measures cannot get to provider level – so should we remove those measures? Those are key quality goals for TX. Eval measures being pulled by EQRO are limited to managed care beneficiaries. State is working on attribution methodology with EQRO.

- Jen – concern is that this is state level data, are you able to isolate to SDP?
- Emily – that is what state is trying to do with EQRO – but cannot do that with certain patient satisfaction measures (CAHPS).
- Liz – can you report out by plan level?
- Andy – for some measures, not all.
- Liz – because VBP arrangements are predicated on provider level performance, would hope they could transfer to eval measures. Do want state to continue to include core measures.
- Emily – because timing of data, VBP measures and eval measures are different sometimes. Instead of other eval measures that are linked to QS goals and objectives, some VBP measures are distinct (i.e., safety measures vs PPE measure). Sort of build on one another.

John – know that Texas team has questions about the concept of payment being attributed to managed care members.

- Andy – For QIPP, have multiple components, and for instance, one is focused on workforce hours. Treat that as a performance-based measure or requirement. But won't be able to attribute to Medicaid managed care beneficiaries only. Question for CMS: can we have components that have variety of measures?
- Laura Snyder – CMS does not have this concern for QIPP. For TIPPS and BHS, pay for performance measures look at Medicaid managed care and FFS; unable to differentiate between two.

TX-CMS Call on 8/24/21 Notes

- Emily – would like to point out the vast majority of Medicaid members are in managed care (95%). To the extent that there are FFS in the denominator, at some point in the year, those beneficiaries would be in the managed care. State does not think this will impact the outcome of the measures.
    - Also want to make the distinction between utilization of services vs achievement of quality measures. Providers in TIPPS and BHS will not get payment if do not deliver services to managed care members. Trigger for payment is utilization.
- Laura – have seen other states do a gradual transition from uniform increases to true VBP arrangements. Right now, TIPPS and BHS have VBP components, which is why CMS had concerns that pay for performance measures included Medicaid FFS beneficiaries.
- Emily – Pay for performance measures are in 3 components (between TIPPS and BHS) – payments are being triggered by utilization but provider must meet quality benchmarks. Other component entails a biannual payment – but must meet utilization requirements.
- Laura – we should work with state to revise TIPPS and BHS preprints since right now reflected as VBP arrangement and the state is indicating that payment is being triggered by utilization, and not performance.

John – For this Thursday's meeting, will plan to have 30 min to continue the quality discussion and 30 min for discussion with FMG on the non-federal share questions.

TX-CMS Call on 8/26/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	April Ferrino	Evan Dial
Rachel Butler	Michael Ghasemi	N Boston
Trey Wood	Stephanie Tourk	D Dillon
Joelle Jung	Emily Zalkosky	A Campbell

CMS Attendance

Daniel Tsai	Layla Fraser	Jennifer Clark	Tom Caughey
Ann Marie Costello	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
John Giles	Allison Weaver	Charlie Arnold	Carrie Smith
Laura Snyder	Elizabeth Clark	Jonathan Endelman	Norina McAuliffe
Juliet Kuhn	Christopher Thompson	Andrew Badaracco	Michelle Beasley
Eli Greenfield	Jeremy Silanskis	Richard Cuno	Daria Romanov
Diona Kristian	Jocelyn Velez	Deborah McClure	James Burns
Shamberkia Wise	Tamara Sampson	Jennifer Maslowski	Amy Gentile
Teresa DeCaro	Rebecca Burch Mack	Mara Siler-Price	Angela Garner
Chris Truffer	Tristan Cope	Paul Spitalnic	Fran McCullough

John – first half of meeting on non-federal share and second half of quality.

Alissa – At end of meeting, will address Gary's question that he sent via email from last night.

Gary – Maggie Griffith and Victoria Grady will kick off non-federal share discussion.

Maggie Griffith – I am Staff counsel for HSSC. If we could go to CMS' questions about LPPFs. In reviewing CMS' questions, CMS is focusing on potential arrangements by hospitals that involve transferring Medicaid payments to other providers. We haven't been able to identify the statutory or regulatory basis for this inquiry – can CMS provide this? These are consistent with the questions Texas sent to CMS.

Rory – have been working with the state for a while on this. We look at the statutory requirements at 1903(w) and what is key is the regulatory requirement at 42 CFR 433.68(f)(3) pertaining to hold harmless arrangements. CMS needs a full and complete picture of what is going on at the provider level related to the non-federal share. There is preamble language in 2008 final rule that talks about when state payments are made available to the tax payer and the reasonable expectation that taxpayer is held harmless for that tax. Essentially, pre-arranged agreement among providers to redistribute Medicaid payment to mitigate cost of tax so that they are held harmless. CMS needs sufficient information from the state to ensure that state to conclude that 1903(w) and the associated regulatory requirements are being met.

TX-CMS Call on 8/26/21 Notes

Maggie – process question. Are you planning to respond to our questions in writing?

Rory – going through information from state. Want to be expeditious and thoughtful. Need to reconnect with leadership.

Alissa – That goes for all state's responses, want to be expeditious and thoughtful in response. Will figure out next steps at the end of the meeting.

Maggie – For state's responses related to bonds, Victoria Grady will go through those Reponses.

Victoria – from the responses:

- Q1: State has confirmed that we do not currently collect this information. Do need anything else from us?
    - Rory – going through the information. Want to be sure state has appropriate oversight. CMS' intent is not to setup a new state reporting requirement.
- Q2: State is willing to provide the info requested but do not have it currently. Would be helpful to get clarity from CMS on when bond is issued through normal process, are those circumstances that you wanted state to collect info on? If not, in what circumstances should we get this info? Would it be acceptable for governmental entity to attest that they do not have bonds?
    - Jeremy Silanskis – want to review this more but initial response is primary concern is with NFS. If bonds are NFS, then that is our concern.
    - Victoria – for general issue bonds, not sure the government entity could distinguish if the bond is being issued for NFS or not. That is what we are trying to distill. Is there any exception if there is not a special purpose to the bond? Just normal business of running a government entity.
    - Jeremy – context is key. CMS would have concerns if state said they were not going to examine the issue. Do think its responsible for localities and state to have this understanding. Having the source of where the IGTs are derived.
    - Victoria – our state comptroller issues bonds as a normal government process. Not expecting state to find every person who may have bought bonds, right? Just financing government business. How are we to distinguish?
    - Rory – has the state asked the localities about these arrangements? From CMS perspective, bonds seem like a broad, statewide mechanism for NFS financing. Seems like a widespread shift for state funding IGTs via bonds. Really just trying to figure out how do we know what is going on. Our role is not to interfere with normal government operations. Ensure that state is partner is the process to ensure that program is financed properly.
    - Victoria – not sure state has seen widespread shift to use of bonds. Not sure if that is the case – can you point how you came to this?
    - Rory – maybe its just that CMS hadn't known about the widespread use of bonds. If this is the case, the state should provide us this information and help assure us.
    - Victoria – there are some government entities who do not have taxing authority, and responded that they have bond authority. Example of the county in Texas who use bond revenues to support the facilities that they own. Can provide CMS history of these type of examples.

    - Jeremy – that is a good starting point.
- Q3: CMS asked about the oversight group we are setting up. The document we sent you describes that path that we have taken for oversight. Started in late 2019 with LPPF oversight. Produced a plan with public comment in the fall of last year. Based on comments, state determined would need additional resources. Over 1,500 local entities that transfer or certify funds. Legislature appropriated additional resources and currently working on hiring additional staff. Plan to roll out plan in 4 phases. All of that is described in that document – describes pathway of how we got to where we are.
- Victoria – on LPPFs, two questions from CMS that we have not discussed. For LPPF reporting, state provided most recent published report and also identified administrative expenses.
    - Rory – question regarding the mandatory payment column. Is that the amount that each entity is sent by the locality? Victoria: Yes.
    - Rory – Is there a corresponding Medicaid payment amount that each of the facility receives? Second key piece.
    - Victoria – quarterly LPPF report. Not always on same schedule. May be taxed on quarterly basis – that gov entity may have different schedules (annual, quarterly). Hard to trace so tried to show you who is transferring and then what programs the LPPF is funding. Payments may not correspond to the timeframe for which they are taxed.
    - Rory – want to think about this more. Q1 is asking to see analysis/data used to make the attestation.
    - Victoria - All IGTs go into one bucket and then payout according to methodology.
    - Rory – will need to think through this. What makes you comfortable to make attestation?
    - Victoria – For the last question that we have not discussed, did have a question about statute or regulation that describes a restriction for how a Medicaid provider can use funds. Not familiar with legal citation.
    - Rory – gets back to 1903(w) requirements and CFR regulations.
    - Victoria – look forward to getting written responses from CMS.

Gary – sounds like at least one more call on non-federal share. Move to quality discussion.

Liz Clark– haven't had a chance to go through state's responses from yesterday. Do the state's questions sent to CMS cover everything you want to know?

Andy Vasquez – want to give you chance to review. Of course, it's in the details – your responses may prompt additional questions. Emily, anything you wanted to highlight? No.

Liz – Jen, anything you want to discuss?

Jen Maslowski – had really good conversation on Tues. One area that we did not touch on was QIPP and not being able to isolate data to Medicaid managed care benes in MDS measures. State uses CMS calculations for MDS measures but state does have raw MDS data.

Andy – use data from CareCompare from CMS for the measure calculations. We could identify the individuals but can get different results b/c methodology may vary. Benefit of being able to pull public data.

TX-CMS Call on 8/26/21 Notes

Jen – are you able to distinguish between Medicaid residents vs other residents?

Andy – it is facility level data, not limited to just Medicaid. For other SDPs, we are able to isolate to just Medicaid.

Jen – are all nursing facilities enrolled in the SDP?

Andy – almost every nursing facility is in QIPP.

Liz – you had mentioned it would take a quite a bit of time for calculating performance results for just Medicaid managed care. Is this part of the attribution plan that you are working on for other SDPs?

Andy – would like further clarify on that. Is this a requirement for QIPP or not? Given the nature of QIPP being solely focused on nursing facilities. It was not initially part of attribution plan for other SDPs.

Jen – understand that data is at facility level. Are all beneficiaries in those facilities in managed care?

Andy – maybe have a few who are new to Medicaid, in FFS but very small numbers. All nursing facility members enrolled in MC.

Jen – trying to get at measurement data is focused on Medicaid managed care data.

Andy – with all Nursing Home Compare measures, its all at the facility level. This is our attempt to apply the same approach.

John – want to make sure we understand. On Tuesday, had a full discussion about what is triggering payment for BHS and TIPPS. Payment functions more like uniform increase and to eligible for payment, provider must meet certain quality component. Want to make sure we understand what is the payment trigger.

Emily – that is right. TIPPS component 3 and BHS Component 1 and 2 are rate enhancements based on adjudicated claims.

John – that's helpful.

Victoria – if not tied to adjudicated claims, then the payment is performance-based and there is a requirement that payment be tied to minimum utilization. This applies to TIPPS component 2 and QIPPS Component 2-4. TIPPS Component 1 and QIPP Component 1 = not adjudicated claims, but based on structural measures.

John – Also really want to convey what our concern is regarding ensuring that payments are being made for improvement. More narrow in scope. The concern is the OIG finding – providers participating in QIPP had declines in performance but still received quality incentive. That is the issue that the IG point out. We know the state attempted to address this with the quarterly improvement schedule.

Andy – some of the questions we sent to CMS are tied to quarterly question. State was trying to consider natural fluctuation in performance and did not want to penalize providers for this. If we can't use that approach, may have to move to a payment cycle where its more of an annual cycle like is being done for newer SDPs. We could say if performance decreases, no payment but than what about high-performing facilities.

TX-CMS Call on 8/26/21 Notes

John – Since few minutes left, let's talk about next steps.

Alissa – not sure if we will have answers by our next meeting but want to to continue talking through issues with state.

Laura – walking through provider data submitted to CMS at a meeting next week would be helpful. Open to Mon or Wed meeting.

Gary – for Monday, would like to discuss CHIRP amount and would like OACT on that call.

John – So for Monday, can walk through reimbursement analysis as part of CHIRP discussion on Monday.

Alissa – CMS will follow-up in writing with response to Gary's question from last night right after this meeting.

August 26, 2021

Sources of Non-Federal Share

Maggie Griffith (MG)

- State Comments – page 12
- Agreements with hospitals
- What are the statutory and regulatory legal basis for this request

Rory Howe

- 1903 (w)
- 42 CFR 433.68 (f)(3) Hold Harmless. Taxpayer hold harmless
- 2008 FR amended. Reasonable, agreements and redistribution
- Assurance. No offset 1903 (w). Have information at provider level to review

MG

- Provided response in writing

RH

- CMS will Review and will respond

Victoria Grady (VG)

- Do not collect information

RH

- Appropriate oversight mechanism is needed. State Oversight overall

VG

- Whether a bond is issued via Public? Do not collect
- Under what Circumstances
- Gov't entity attest

Jeremy Silanskis (JS)

- Non-federal share must collect for NFS. Provider class. Who is contributing?

VG

- Bond Obligation. No review of bank account and use. Most likely general government purpose fund.
- Normal routine of running government

JS

- Purpose or intention of funds. Must have appropriate oversight and the underlining information.
- Where is the IGT derived.

VG

- Controller issues bonds. Do not have everyone information of who purchased.

RH

- State ask localities? Have that asked providers? Providers contributing. Non-government entities. Funding source.

VG

- Where is CMS seeing the widespread use of bonds?

RH

- If historical provide details and information. Providers / Private

VG

- Some entities have bond authorities – Central Texas? Do not have taxing authority.
- Funds. IGTs source of bonds

JS

- Governmental Providers financing?

VG

- Issuing bonds to fund facility
- Oversight Plan. 2019 reporting LPPFs. Plan with public comment. Identified 1,500 entities. Need rule making, 4 phases, providers, CPE.
- Information Reporting.
- All in the document. Attachment C

RH

- State attest. Information and data used to make attestation.

VG

- IGTs. Not 1 to 1. Pooled. No direct correlation

RH

- Understand. What make states comfortable with process???

VG

- What statues / regulations on the restriction on how a provider uses funds for services

RH

- Statues and Regulations provided earlier

VG

- Needs CMS feedback / response.

<u>9/1/21</u>

Rory, Alissa, Texas reps: Gary Young, Stephanie

- Financing Qs from Rory. Two groups of issues:
  - IGTs sourced through bonds or other debt instruments
  - LPPFs
- IGTs financed through bonds/other debt instruments
  - Generally, CMS has concerns about these instruments to turn into bonafide donations. Continue to encourage Texas to incorporate into oversight plans
  - #2 from our Qs from a couple weeks ago are still the most relevant.
  - Home in on arrangements: important to communicate with localities to try to get an accounting of whether providers/others are in the mix
  - Excel spreadsheet listed 9 entities that don't have taxing authority. So those might be good places to start asking those entities
    - Andrew: We created a spreadsheet with IGT lists with all payments. TX identified which ones had taxing authority or received approps. Nine had neither.
    - We will provide to Txas
  - Attestations: it would be OK for localitites to say they are complying. That would be sufficient. But there may be times when an attestation may be necessary that localities' bonds don't have all providers. Could make the attestation required under the agreement.
  - Gary: are there any states with agreements that would be compliant?

        - Jeremy: we have not approved any bond/debt instruments so we don't have anything directly responsive. Could be just listing entities associated with bond holders. Or they could attest that they know that there are not providers as bondholders.
    - Jeremy: we are not asking new information, but rather just asking for documentation to comply with nonbonafide donations and in compliance with 1903(w). Not asking for regular reporting.
    - Victoria Grady: Building this into our process for oversight plan, which is being constructed to be implemented prospectively. So for SDPs, would we need documentation that would be included. What would be needed now?
        - Jeremy: no one knows who is contributing. So hard to say that underlying financing is OK.
        - Rory: we can take it back to get to clear expectations
        - Victoria: please clarify if you are looking for the info for 9 entities, or from every gov't entity participating across the programs.
- LPPFs. Rory: attachment C information that Tx provided on tax amounts by locality and provider. We noticed several LPPF exclude several hospitals from the tax. Our previous understanding was broad-based/uniform. If there are exclusions, we need to analyze.
    - Victoria: no government entity running an LPPF that can exclude providers except for publicly-owned providers, which are excluded.
        - This is 1 Q of data, so the list might reflect that some providers haven't paid the annual tax in the time frame
- Rory: Attach C, Bowing County and Webb County: no hospitals appeared to be taxed at all. So that may reflect the timing issue.
    - Victoria: will provide more specifics
    - Gov't entities don't have to levy an assessment every year. So some may not assess mandatory tax every year

- Attestations where providers receive the funds back. Texas said that the state could attst to it. CMS was looking for each entity to attest to it and wants to see the amounts sent to each provider. Our original request would provide the information necessary. Want to know how TX could attest to it without the data.
    - Victoria: because payments are not tied 1-to-1 basis. The particular locality tax may be funding the program in general but the taxes are all pooled. Attestation was guaranteeing that the taxpayer would not receive back their initial funds. Happy to do the analysis and provide it to you.
- LPPF: Nopayment redirections, pooling going on. Texas asked for the basis of our concern in regs. We have provide it verbally. This issue is still outstanding. Do you have the information you need from CMS?
    - Victoria: want it in writing. Some of the elements were in preamble not statute/reg. If provider attested they were in compliance with 1903w and …63 since those are the right regs would that be satisfactory?
    - Rory: attestations unlikely to suffice between we haven't had a chance to look at the arrangements
    - Vic: providers in a locality with a tax, right? LPPFs are in limited jurisdictions.
        - Rory: yes. Concern with any entity paying hc taxes
    - Vic: concern is pooling/sharing Medicaid payments?

        - Rory: yes. Make sure what that means. We can be more precise if need be. Don't want to be in a position where a state is saying that once payments are pooled, they stop becoming Medicaid payments.
        - Vic: if our providers attest that they are not engaging in impermissible relationship where redistributing, there'd be no add'l data furnished for examination.
        - Rory: we don't have the agreements themselves. That would be helpful.
        - Victoria: even if we get the attestations, it may not have the underlying data
        - Rory: we could analyze the agreements; if they are not available, then the attestations might get there, leadership pending
        - V: we could get entities to attest to CMS language, or to a broader citation to statute/reg
        - Rory: yes. We could work with you.
        - V: Stat granted authority to require anything since stat/reg speak to entities' involvement.
        - R: we could do some more framing re: statutes/regs, but yes those statements are essentially the right thing
        - V: Not committing but will look into it.
- Laura Snyder: potential for payment to entities that decline in performance

<u>Texas meeting 9/14/21</u>
John Giles, Rory, Amber,
Gary Young, Victoria Grady

attestations on NFS

- Victoria: you're not asking for information right now, but rather prospective, for developing the oversight plan. You (CMS) wants info going forward.
    - Jeremy: yes
- Victoria: New director, Francis Morgan, of local funds started yesterday. Item 3: next steps are underway so making progress.
- LPPF: able to conduct the analysis under Item 2. Will include it with written responses. Have 28 authorized jurisdictions. Only 26 were active in doing an assessment. Two were not fully operative in FY20.
    - Went through and compared paid assessments in FY20 to Medicaid ___. One provider did not receive $ to cover their assessment.
    - Two jurisdictions did not have that situation. But paid more than what LPPF would have permitted. Maid payments are not correlated. In both cases, based on our analysis, no causal relationship between Medicaid amount received and payouts from LPPF. It's
    - Ellis and McClennen county. Only two hosps in ea county subject to the tax.
        - Ellis: 28% more IGT would have been needed to receive. So funds coming from other sources
        - McClennen: 37%
- We will be reaffirming the attestation that no causal relationship between IGTs and LPPF.
- Rory: When you're providing the data, be clear about definitions of data.
- Victoria: opportunity for hospitals to attest. There are 650 hospitals. Some don't receive Mediaid payments. So it's helpful to have a singular attestation. Prepping response.
    - 1903(w) and 433.68. Will make attestation on all provisions of F, not just (F)(3)

    - Rory: that's a pathway. Not looking for just those two citations. Looking for attestation that's supported by evidence, that the agreements don't exist.
    - Victoria: will have to confer with counsel

Texas 9/30/21

- For 36 facilities identified for nonpayment
    - 9 cherokee or nuasis county. Didn't assess a tax (had the authority but didn't assessed)
    - 3 were blank rows
    - 5 are sub-parts of hospitals. They are really one entity. The parent entity paid full amount
    - 7 were duplicative, duplicate TINs
    - 12 remaining
        - Clarity Child Guidance: confirmed with gov't entity: doesn't meet def of providing inpatient care according to 42 CFR 440.10
        - Others: taxpayers are delinquent
        - New facilities: no data on which to base an assessment because it's levided based on net revenue from prior period
    - Where entity didn't get any amount: no correlation between amount facility paid and amount received through Medicaid program.
- Re attestation of no hold harmless. Fed law allows us to attest on behalf of the state. Reiterating and include as part of plan for ongoing monitoring. WIll include info for local gov'ts to certify. Reg doesn't extend beyond units of gov't and their providers.

TX-CMS Call on 8/30/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
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Andy Vasquez	April Ferrino	Evan Dial
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Linda Hunyh		

CMS Attendance

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Teresa DeCaro	Rebecca Burch Mack	Mara Siler-Price	Angela Garner
Chris Truffer	Alexis Gibson	Paul Spitalnic	Fran McCullough

Victoria- we sent CMS an analysis based on your questions specific to UHRIP-only hospitals. Included some things that CMS requested and some additional information. Happy to start talking through it.

Alissa – ok, we'll start there with reimbursement level analysis discussion and then will talk about total dollar amount agenda item.

Laura – would like to confirm our understanding of each of the tabs in the Attachment A spreadsheet provided by the state:

- Tab 1 – only UHRIP hospitals by class and how reimbursement will compare to ACR. Excludes the 17 UHRIP-only hospitals for which state does not have ACR data. These hospitals are excluded from the denominator for the ACR calculations but not numerator.
- Tab 2 – all hospitals by class. Regardless of ACIA and URHIP. Total aggregate dollars for full class and imposes the 90% cap that the state proposes making. Can you walk us through where the 90% is applied?
    - Victoria - Considers total payment for CHIRP for each facility and the 90% is applied to the available ACR UPL room for that class.
    - Laura - For UHRIP-only hospitals that exceed ACR, are they getting capped at 90%?

        - Victoria - Yes, they would be factored in b/c they would be exceeding individual ACR and that would impact aggregate room for the class.
            - Cap at 90% at aggregate for class based on ACR UPL. First apply analysis to get to Medicare UPL for class. We know that some hospitals have Medicare UPL room above ACR and that limits the class ACR room.
    - Laura - When seeing negative numbers in the spreadsheet, what does that represent? Reductions of payments in class from what was originally captured?
        - Victoria - For instance, Bexar SDA state owned non-IMD, they had $8,200 Medicaid base and did not have ACR data. B/c no other hospital in class = de facto would result in $0 payment.
- Tab 3- looked familiar from previous rounds. All hospitals. Is there any difference in data presented here from what state has previously shared? Victoria - No just took some columns out.
    - Laura - There was one hospital that seemed to be removed from last round. TPI # 1154893675. Possibility that the hospital closed but Victoria will check.
    - Of the hospitals only participating in UHRIP and not receiving ACIA, there are 106 that would be receiving payment above ACR. Cuts across a few of the SDA and classes.
- Tabs 4-5 – same data from tab 3 but limited to those hospitals just participating in UHRIP. Outpatient and inpatient have separate tabs.
    - Laura - Was there an increase in outpatient payments? Some of early CMS' analysis, went from $456M to $659M for outpatient CHIRP and may be driven by UHRIP only hospitals? Victoria – No, should not have been a change. We'll look into it.
    - 176 hospitals only participating in UHRIP inpatient and 178 hospitals only participating in UHRIP outpatient.
- Laura – are there other questions from CMS?
- Layla Fraser, OACT – for the proposed reduced estimated program size of $4.7B total, does that include not benefit load?
    - Victoria - Yes, Payment to providers and additional managed care expenses.
    - Layla – for the proposed 90% cap by class, has the state done any work on how this would translate to uniform rate increases?
    - Victoria – No, first wanted to check with CMS if this approach of applying cap to class level was appropriate. Lot of work to rebuild model so first wanted to check with CMS.
    - Layla – confirm that cap would apply to both UHRIP and ACIA? Yes
- Laura – back to tab 1. Make sure translating it correctly. If we look at nonstate owned IMDs for Bexar, 306% of payments for class. For the hospitals that only receiving URHIP, their payments would be 306%. When include all hospitals, would be 101% of Medicare.
    - Victoria - Also see similar thing happening in urban. Same phenomenon. Only receiving UHRIP component, as a class they are over 151% of ACR. If bring in all hospitals, brings down to 95% of ACR as of class b/c rest of those hospitals not getting excess ACR. Depends on if you are subdividing, the numbers can look sort of funny.
    - 17 UHRIP-only hospitals did not provide data, so rest of UHRIP-only hospitals had their Medicare UPL above ACR.

TX-CMS Call on 8/30/21 Notes

- Victoria – could we talk about 90% limit that the state proposed to CMS? Per our state regulations, it's a change we could make within existing programmatic rules. Would this get CMS closer to where you need to be?
    - Alissa- need to have internal discussion, not ready to opine at this moment.
    - Victoria – figured that was the case, let us know if is there anything else you need.

Stephanie – next agenda item. Total dollars for option 1 specific to UHRIP.

Rachel Butler – also have Evan Dial on phone. Want to provide additional information on extending UHRIP for SFY 2022. Unlike QIPP, this payment is made at claim adjudication. When assess capitation rate change impact, we modeled what the provider payment increase would look like and look at trend factors that account for acuity and utilization changes. We had provided an estimate for SFY 2022 if applied exact same assumptions for reimbursement to CMS. Accounted for changes that took place in March 2021 and for aggregate costs, and then multiplied by projected case load. Significant growth due to public health emergency. $3.33B is the projected estimate for SFY 2022 UHRIP – column 4 from Gary email Friday afternoon.

Laura – basic question. Last year, when SFY 2021 preprint was submitted, the state projected $2.7B for UHRIP. Know a mid-year change occurred. For SFY 2022 for CHIRP, the estimate for UHRIP component was $2.4B. Why did numbers change?

Victoria – the UHRIP methodology for SFY 2021 was an either or methodology. Class got either Medicare UPL or what the got in SFY 2020. Did have classes that were exceeding Medicare UPL. For SFY 2022, UHRIP was limited to 100% of ACR by class and also redefined classes to more align with state plan definitions. Would help explain the $2.7B to $2.4B.

Rachel – also on case load. When working on UHRIP for SFY 2021 – did not have visibility on PHE and how would impact Medicaid case loads. Now in hindsight, the aggregate amount is a function of case load. Put capitation rate add on doesn't take case load into consideration. Didn't know about this in Feb 2020. Did try to provide UHRIP calculations sent on Friday for case loads for SFY 2021 and projecting case load a little lower for SFY 2022.

Laura - when projections for CHIRP were provided for preprint SFY 2022, was the same caseload projection used? Understand that the caseload changes over time. Did it account for PHE at that time? Or was it an older case load?

Rachel – SFY 22 CHIRP amount had caseload forecasts and provider rate increases. Finding sweet spot.

Victoria – at time we made projections, increased case load for anticipated base encounter payments and what ACR/Medicare UPL room looks like. When pull from Medicare UPL room, use last year's Medicare data and do not trend those because want to be able to trend to old Medicare data. So the historical Medicare UPL does not take into account that there was a caseload that is 30% lower than what it actually was.

Tristan Cope, OACT – thank you explanation. You had mentioned that delivery and pregnant women contributed to driving increase in total dollar amount estimates?

- Rachel - Star program saw an increase in enrollment (not specific to just pregnant women). Have not seen as much enrollment change for Star Plus program (aging and disabled population).

TX-CMS Call on 8/30/21 Notes

- Tristan – do you expect case load increase for SFY 2022? What are your projections?
- Rachel - We are expecting a decrease at some point. A lot of it is TBD. Now we have caseload visibility. Expect it eventually to taper caseload – same forecast that we used in April/May for base rates that we sent.

Laura – is the forecast last available from March/April? Make sure following – when estimates for preprint were done in March, was the same forecasts used?

Rachel – Medicare UPL demo is used when developing individual hospital rates and that is done same time as case load projections – and those two things come together. For CHIRP, legacy being applied to projection. But when go backward to bring historical rates forward, rates set back in June 2020 were based on demo from fall of 2019 and caseload that had no PHE impact.

Laura- understand that these estimates are built into capitation rates each year. $2.67 is quite different from $3.3M. Is that a change that you normally see? Is that gap what you see from year to year?

- Victoria - 100% unique to this year and the PHE. Economic impacts. Michael Ghasemi is director of forecasting, who can speak to this more.
- Michael – absolutely an anomaly. Since April 2020, have seen growth rate of 30%. Would take 10+ years to see that growth normally. Outside of what would be close to normal.
    - Under normal circumstances, variation is less than 1%. Reason not seeing this in QIPP is because enrollment growth is by pregnant women populations. Aging and disabled population do not fall off and on Medicaid as easy.

Rachel – change from $2.67M and $3.3 was really the PHE. Mid-year adjustment was very little impact ($50K?).

Alissa- for call on Wed., how would you like to use the time?

Stephanie – sent CMS some responses. Ready to speak about any of that?

Alissa – need to get back to Dan, specifically on items discussed today. We will check with quality and Rory on topics ready for Wed.

Stephanie - Still expecting written responses on health equity.

Andy – for quality and health equity questions, even if don't have definitive answers, would be helpful to discuss any questions CMS may have.

Alissa – definitely. And will connect with SDG on health equity questions. Thank you, particularly Tory, for walking through the data today.

TX-CMS Call on 9/1/21 Notes

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Alissa – have some follow-up questions. Start with financing.

Rory – few follow-up questions. There are two buckets of questions. Focus first on bond issue. Turn to Jeremy.

Jeremy – did have opportunity to go through state's responses. General comment – continue to have concerns bonds may be provider-related donations. Continue to encourage state to include this in oversight plan. On the state's question to CMS on honing in on the type of entities/arrangement, important to go to the localities and see who is contributing and if providers are in mix. There looks to be 9 entities that do not have taxing authority so that might be a good place to start.

Andrew B – to clarify, we created a spreadsheet using IGT list from all Texas' SDPs (BHS, TIPPS, etc.). Within that list, there were 9 entities based on the info that the state provided during the preprint process that do not have taxing authority.

Jeremy – re: question about attestations, there might be scenarios where localities could substantiate and the state could have attestations to that effect on underlying information. CMS can certainly work with state on this. A lot of states have IGT agreements with localities and that could be a vehicle for this type of attestation or could be a condition of participation for SDP.

TX-CMS Call on 9/1/21 Notes

Gary – any states to point to with the IGT agreements?

Jeremy – CMS has not outwardly approved bond arrangements. But could be as simple to furnish the info as outlined in #2 of the response document. Want to clarify for the state that do not need to report anything to CMS. Trying to set the state up to be in a good place to ensure compliance with the in a provider related donations regulations/requirements.

Victoria – for purposes of SDP approval, do you need us to provide you documentation? What is the deliverable that would ease your concerns for the SDP approvals?

Jeremy – right now, we do not know who is contributing so puts us in a difficult spot.

Rory – Victoria, it is a fair question. Ultimately can take the question to our leadership to get you clear expectations. Know we are working toward that clarity and can follow-up with specificity.

Victoria – for when you specify whatever information you need, please let us know if you need the information the 9 entities you identified vs all entities. Help inform information collection.

Rory – any other questions on bond issues? Also have questions on LPPFs. First have questions on Att C information that state provided on tax amounts. Noticed several hospitals appear to be excluded from the tax. Previous understanding what that these were broad based and uniform taxes. Why hospitals excluded from tax?

Victoria – general answer is no governmental entity can exclude providers, except for public providers. Data provided to CMS was only from 1 quarter, so you might not be seeing that entity report for that quarter since its an annual tax. Happy to answer specific questions. No exclusion permitted by state law.

Rory – very helpful. Also on Att C, for 2 LPPFs (Bowing and Webb county), no hospitals appear to be taxed. May be because of the timing issue that you mentioned. Would like more info on that.

Victoria – happy to provide more specifics. Report provided was a snapshot in time. In general, entities do not have to levy an assessment each year. We have some entities that may be in operation but not taxing actively.

Rory – next question on attestation regarding no localities imposing a tax where all hospitals paying the tax receive their total tax cost back in the form of Medicaid payments funded by the tax. CMS is looking for detailed analysis to show tax information broken amount by locality and the amounts provided back to provider. Didn't see that in Att C – what did the state do to make that attestation?

Victoria – interpreting that attestation that there was no hold harmless arrangement but can look at it from the aggregate too.

Rory – CMS will send a follow-up question in writing to that extent. Last question, state had asked for legal basis for requesting that the state provide an attestation regarding participating hospitals transferring, redirecting, redistributing Medicaid payments to other Medicaid providers. Wanted to flag that this attestation is still outstanding.

Victoria - Would like to see responses in writing with the legal references. If a provider attested that they comply with 1903(w) and the associated regulation, would that attestation be sufficient?

Rory- we can take that request back to discuss internally. Problem is that once we identify that there is a questionable arrangement in place, we have obligation to look it. And we have not had a chance to make determination one way or another. Likely will look again at the specific attestations.

Victoria – LPPFs are in limited in jurisdiction…

Rory – concern resides with any entity that is funding the tax.

Victoria – and the concern is about the transferring, redirecting, redistributing Medicaid payments to other Medicaid providers?

Rory – our goal is to look at what is going on. Trying to come up with pathway for compliance. But generally, yes, that is a concern. Once Medicaid payment is received, and it matters what happens in back end with the money moving around. Want to look at agreements and see what is going on.

Victoria – if providers provide attestation that they are not engaging in impermissible arrangements, there would be no additional data furnished, right?

Rory – we have not asked for the agreements themselves. We are in a position where we do not have any of those arrangements but state has indicated that they exist.

Victoria – continue to have concerns that we do not have legal basis to ask providers to provide attestation. What do you need from us to resolve concern?

Rory – We could analyze agreements. Unlike the bond issue, there seems to be a discreet concern. If these agreements can be provided to us, than the attestation is a pathway.

Victoria – state still has question on legal authority to require anything of providers.

Rory – happy to work with state on language.

Victoria – not ready to commit one way or another but helpful to know CMS' expectations.

Gary – please send list of 9 entities, Jeremy.

Alissa – follow-up questions on reconciliation.

Laura – follow-up questions on performance declining and also reconciliation. Preference for where to start?

Gary – is the first QIPP related?

Laura – QIPP and TIPPS related. The one component of TIPPS that is still performance based. Concern around payments based on performance not being based on year over year improvement. Clarify that concern is being driven by OIG finding. That is the big driver for us. Know that state made changes for QIPP component 3 but concern exists that there could be particularly high performing providers who get payment but may have declines in performance.

Andy – that does make sense. Recognition that there is a band where there can be fluctuation so not indicative of downward trend. Want to allow for a little fluctuation. Do understand the concept that you are describing. Based on our experience, hard to have absolute zero decline. Want high performing providers to continue to be high performing and improving wherever possible – have concern where

there is high performance with high benchmark, then it could be satisfactory for them to maintain. Considered to have met measured. Decline vs maintain.

Laura – that makes sense and that came through via the questions. In another program, do have a band to distinguish between fluctuation vs performance decline. Can speak to the band more?

Andy – referring to provider P4P program and do not know specific off top of head.

Emily Sentilles – benchmark vs IOS measures in TIPPS. If maintain benchmark, does that not satisfy CMS?

Laura- would like to understand what is state perspective to address concern. Some other states have looked at applying IOS when provider satisfies benchmark. Also would this type of change be possible for SFY 2022, since we understand a lot of quality is in the state's administrative rules?

Emily – would need to take that back. Part of the reason looked at benchmark measures for TIPPs was because it is the first year of the program. If have really high performer, don't want to penalize them. Across all of these programs, trying to find measures that all providers can use.

Laura – do appreciate this concern. Would be helpful to understand the band being used in the other program.

Emily – would like clarify is CMS expectation about year over year performance for evaluation purposes too?

Laura – I believe that is correct but defer to DQ.

Jen Maslowski – that is correct. Although talking about QIPP, want to see across SDPs. Similar discussion that you were having with Laura and applying that to other SDPs. Does that make sense?

Emily – I think so.

Laura – we have discussed the main questions that I had. To recap, would like to understand how you use brackets currently and if we were to go down this road, would this be possible for SFY 2022 given admin code.

Andy – we will take a look at it from that standpoint. Combined IOS and benchmark approaches- would be helpful for CMS to provide examples if possible. Want to come back to types of measures – okay to have benchmark measures? Particularly for programs in their infancy.

Laura – generally, considering OIG finding, when setting benchmark, needs to be set appropriately. Want to be sure payments are supporting maintenance or improvement.

Andy – is there room for structure measures and process measures? Or really moving toward outcome measures? Ex – QIPP component 2, you either satisfy the measures or not. Hope that there is room for these structural measures.

Laura – still talking internally. Strong, strong preference on outcomes. Structure measures are difficult.

Andy – intent is for early years and increase rigor over the years.

Gary – time to talk about reconciliation?

TX-CMS Call on 9/1/21 Notes

Alissa – will reserve Friday 2pm time for reconciliation questions. And state should let us know if have additional agenda items.

Gary – sense of written response timing from CMS?

Alissa – will have a better sense next week. Know that Dan was going to have separate conversation on Option 1. Good stopping point.

9/1/21

Rory, Alissa, Texas reps: Gary Young, Stephanie

- Financing Qs from Rory. Two groups of issues:
  - IGTs sourced through bonds or other debt instruments
  - LPPFs
- IGTs financed through bonds/other debt instruments
  - Generally, CMS has concerns about these instruments to turn into bonafide donations. Continue to encourage Texas to incorporate into oversight plans
  - #2 from our Qs from a couple weeks ago are still the most relevant.
  - Home in on arrangements: important to communicate with localities to try to get an accounting of whether providers/others are in the mix
  - Excel spreadsheet listed 9 entities that don't have taxing authority. So those might be good places to start asking those entities
    - Andrew: We created a spreadsheet with IGT lists with all payments. TX identified which ones had taxing authority or received approps. Nine had neither.
    - We will provide to Txas
  - Attestations: it would be OK for localitites to say they are complying. That would be sufficient. But there may be times when an attestation may be necessary that localities' bonds don't have all providers. Could make the attestation required under the agreement.
  - Gary: are there any states with agreements that would be compliant?
    - Jeremy: we have not approved any bond/debt instruments so we don't have anything directly responsive. Could be just listing entities associated with bond holders. Or they could attest that they know that there are not providers as bondholders.
  - Jeremy: we are not asking new information, but rather just asking for documentation to comply with nonbonafide donations and in compliance with 1903(w). Not asking for regular reporting.
  - Victoria Grady: Building this into our process for oversight plan, which is being constructed to be implemented prospectively. So for SDPs, would we need documentation that would be included. What would be needed now?
    - Jeremy: no one knows who is contributing. So hard to say that underlying financing is OK.
    - Rory: we can take it back to get to clear expectations
    - Victoria: please clarify if you are looking for the info for 9 entities, or from every gov't entity participating across the programs.
- LPPFs. Rory: attachment C information that Tx provided on tax amounts by locality and provider. We noticed several LPPF exclude several hospitals from the tax. Our previous understanding was broad-based/uniform. If there are exclusions, we need to analyze.
  - Victoria: no government entity running an LPPF that can exclude providers except for publicly-owned providers, which are excluded.
    - This is 1 Q of data, so the list might reflect that some providers haven't paid the annual tax in the time frame
- Rory: Attach C, Bowing County and Webb County: no hospitals appeared to be taxed at all. So that may reflect the timing issue.
  - Victoria: will provide more specifics
  - Gov't entities don't have to levy an assessment every year. So some may not assess mandatory tax every year

- Attestations where providers receive the funds back. Texas said that the state could attst to it. CMS was looking for each entity to attest to it and wants to see the amounts sent to each provider. Our original request would provide the information necessary. Want to know how TX could attest to it without the data.
    - Victoria: because payments are not tied 1-to-1 basis. The particular locality tax may be funding the program in general but the taxes are all pooled. Attestation was guaranteeing that the taxpayer would not receive back their initial funds. Happy to do the analysis and provide it to you.
- LPPF: Nopayment redirections, pooling going on. Texas asked for the basis of our concern in regs. We have provide it verbally. This issue is still outstanding. Do you have the information you need from CMS?
    - Victoria: want it in writing. Some of the elements were in preamble not statute/reg. If provider attested they were in compliance with 1903w and …63 since those are the right regs would that be satisfactory?
    - Rory: attestations unlikely to suffice between we haven't had a chance to look at the arrangements
    - Vic: providers in a locality with a tax, right? LPPFs are in limited jurisdictions.
        - Rory: yes. Concern with any entity paying hc taxes
    - Vic: concern is pooling/sharing Medicaid payments?
        - Rory: yes. Make sure what that means. We can be more precise if need be. Don't want to be in a position where a state is saying that once payments are pooled, they stop becoming Medicaid payments.
        - Vic: if our providers attest that they are not engaging in impermissible relationship where redistributing, there'd be no add'l data furnished for examination.
        - Rory: we don't have the agreements themselves. That would be helpful.
        - Victoria: even if we get the attestations, it may not have the underlying data
        - Rory: we could analyze the agreements; if they are not available, then the attestations might get there, leadership pending
        - V: we could get entities to attest to CMS language, or to a broader citation to statute/reg
        - Rory: yes. We could work with you.
        - V: Stat granted authority to require anything since stat/reg speak to entities' involvement.
        - R: we could do some more framing re: statutes/regs, but yes those statements are essentially the right thing
        - V: Not committing but will look into it.
- Laura Snyder: potential for payment to entities that decline in performance

TX-CMS Call on 9/3/21 Notes

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Carrie- thank you for joining a call on Friday before holiday weekend.

Laura- wanted to talk a little more about reconciliation threshold. Sounds like state is proposing – for QIPP, RAPPS, TIPPS, and BHS, that initial payments would be based on historical utilization and then reconciled to actual utilization. We have had states propose similar proposals in the past. Every payment would be reconciled, correct?

Victoria – correct.

Laura – would initial payment be based on last year and then an addendum would be sent to plans for how to do reconciliation?

Victoria – plans get paid each month, and they would be directed to pay interim payment and then within 120 days of end of rating period (about same time of claim runout), would tell plans to do reconciliation. All payments will be based on actual utilization but from cash flow perspective, providers wouldn't have to wait for payment.

Laura- sounds like there could be recoupment from providers, but not for plans.

Victoria – yes. I know for instance CA adjusts actual PMPM amount after they know what the actual amount is.

Laura – also wanted to ask as we understand that the Reconciliation threshold is captured in the state's administrative code. Would state need to amend this code for SFY 2022 rating period?

Victoria – state made this offer to CMS knowing that we would be taking on risk that we could be sued for deviating from state code. However, we think it is more important to be working collaboratively with CMS.

Laura – appreciate that. Just want to understand what would be required from state. Given that, assuming you go forward with Option 2, would you be able to make this change back to the start of the rating period?

Victoria – yes but we would be taking on risk to do so.

Laura – would these directed payments still be accounted for in the capitation rates as an adjustment to the base rates? Or would the state do it via a separate payment term approach?

Victoria – MCO capitation rates would not be affected by this change. Capitation rates already assumed a certain amount of risk under the former approach.

Laura – We know the state already submitted SFY2022 rates. Anticipate needing to make changes to these rates?

Victoria – not for this topic but may need to depending on where we land with other proposals.

Laura – Assume these answers apply across the 4 proposals?

Victoria – yes.

Gary – want to clarify, is the reconciliation threshold % the issue for CMS? Or reconciliation to historical utilization?

Laura – reconciliation threshold is unique to Texas. CMS generally advises states to pay based on actual utilization. Any other questions from state?

Victoria – state is hopeful to get some response from CMS soon on whether this path is viable or not.

Laura – yes understand, we are still having internal conversations with leadership.

Victoria – if this solution is not a viable for CMS, would be helpful for CMS to identify alternatives. Constructive criticism.

Laura – I think I can comfortably say this does get us closer but still need to get CMS leadership sign-off.

Carrie- any further questions?

Alissa - Suggest we send out a hold for our next call for Wed. and handle agenda items via email on Tuesday.

Stephanie - that works.

TX-CMS Call on 9/3/21 Notes

Alissa- have a great weekend everyone.

TX-CMS Call on 9/3/21 Notes

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Chris Truffer	Alexis Gibson	Paul Spitalnic	Fran McCullough
Alex Loizias			

Alissa – Thank you for the letter sent yesterday. We're reviewing it. Understand you sent email with more info about caseload growth under UHRIP and Option 1. We have a couple questions that we've identified.

Rachel – We wanted to provide additional information on UHRIP and how it operates and the actual spend for UHRIP. For SFY 22, we're not proposing increases to the program itself, it's the exact same program that went into effect March 1, 2021.

John – We do have a few questions, some of them should be pretty easy to answer. Since caseload growth for pregnant women and child was the cause of the increasing dollars for the STAR program, did the state see similar growth in other programs e.g. STAR+?

Michael – The vast majority of growth was in STAR. Our growth has mostly been in non-disability, low income populations. For disability programs such as STAR+ there's been some growth but it's minimal in comparison. The growth in STAR is primarily due to the PHE and new eligibility standards. Absent policies that would result in less turnover in programs, the STAR+ program would generally be less impacted because there's less turnover in that program compared to the STAR program where

beneficiaries experience more volatility in income changes that then results in disenrollment in the STAR program.

Rachel – To clarify, UHRIP is not a program under the STAR children program.

John – On that point, has the state observed any recent declines in caseload growth in the program or, do you anticipate that caseload will continue to grow into SFY 2022?

Michael – As part of our calculations and assumptions for rate development, the latest forecast assumes that the PHE will remain in effect until Dec 2021 so in Jan 2022 and forward we start to forecast a drop in caseload to account for disenrollments as PHE policies wind down. And then we'd expect a gradual decline throughout the remainder of the fiscal year as renewals come up.

Laura – If the PHE was extended beyond Dec 2021, would the state then come in with a mid-year adjustment to account for that extension?

Rachel – No, the caseload is not a factor in determining the capitation rates for the UHRIP add on, at least from a prospective basis.

Laura – I'm asking not just about adjustments to UHRIP but rather would the rates need to be adjusted to account for caseload growth due to PHE because there are more member months?

Rachel – Yes, the actual caseload would impact total spend. For example, we saw that the QIPP case load dropped and therefore the total spend dropped as well.

John – Would you anticipate needing to make any amendments to the SFY 22 rate certifications or are these assumptions already included in the rates?

Evan – Any changes to the caseload are not going to impact the rates we're certifying for SFY 2022. All the rates are calculated based on average cost per member. The only thing that would result in a rate change would need to relate to the actual spend per member. But the number of beneficiaries in STAR or STAR+ doesn't change the amount being paid out per member for those programs.

John – That makes sense to me. Does TX have any data, even preliminary, that supports the estimated 30% caseload growth increase?

Stephanie – We do have some caseload data we sent to Judith and Dan.

Michael – We have monthly enrollment data for the overall Medicaid program by risk group and rate cells. In terms of the 30% figure, that's in the file Stephanie just mentioned. The percentage change is an overall Medicaid growth figure, a year to date figure.

Stephan – I just sent it to Gary so we'll send it over to broader CMS group.

John – Thank you.

Laura – Having not seen the file, some of this seems to boil down to the case load growth for pregnant women and kids. Does the file you're going to share already break it down so we can see the growth for those groups? Or is it just higher level, aggregate data?

Michael – the file being referenced includes overall figures but we can provide it by risk groups e.g. pregnant women and low-income children to demonstrate what's driving caseload growth.

Laura – If possible to provide, that would be helpful.

Evan– I did want to clarify my earlier comment. The rates that we submitted include CHIRP and if those or UHRIP totals change based on the directed payment review process with CMS, then yes, we'd need to submit an amendment.

John – Thanks for clarifying. Case load aside we wanted to be sure that we're understanding that for an Option 1 scenario that the percentage increased you implemented in PY 4 would be the same for SFY 22. The only thing really driving the increase in program size is case load growth. But we wanted to confirm it'd be the same percentage increase per group from Year 4 to 5.

Rachel – Yes, it's the same as the UHRIP increases that were implemented March 1st.

Laura - So that would include the amendment for IMDs? So, the rates approved through last fall plus the addition of that class?

Victoria – Correct, at the time fall rates were approved we used UPL data but at the time we didn't have UPL data for the IMDs so once we had that we used that data to develop the rates for March 2021.

Evan – There really isn't a change for UHRIP from 2020 to 2021, the change actually occurred in 2021 because of the caseload growth. The cost growth of UHRIP is due to the cost projection for 2021; actual cost was higher than projected because the case load was much higher.

John – Our next question is related to the provider class. In the new preprint the state modified the provider class from PY4. How does the change in provider class impact Option 1?

Victoria – We initially proposed a provider class change in PY5 to align with State Plan provider class definitions for inpatient hospitals. But we've realized to maintain the same rate percentage increases we can't do that so we're planning on sticking with the PY4 class definitions.

Laura – There are approximately 419 hospitals under CHIRP. If you go back to old class def under PY4 would the number of participating hospitals change?

Victoria – Yes but it's because CHIRP was voluntarily whereas UHRIP is mandatory. So, hospitals that opted out of CHIRP would be required to participate in UHRIP.

Laura – What's differential in provider number between PY 4 versus PY 5?

Victoria – We don't have that handy but it's comparable to CHIRP.

John – Does CMS have any additional questions?

Laura – There's been a caseload increase that's resulting in increasing total payments for UHRIP. I'm curious if the estimated spend for CHIRP would need to be updated to account for caseload growth there too – it's currently 5.02 billion dollars.

Victoria – The CHIRP preprint submission and associated calculations were done in March and we provided updates in April. The data set used for the forecast at that time included the bulk of caseload

growth projection. The rates submitted in July may have used a slightly different trend factor but it's right in the neighborhood. We wouldn't expect a substantial difference.

Gary – I just sent you the aggregate exhibit that Stephanie referenced but I think you're asking for more caseload details?

Laura – Michael said you could provide it broken down by risk group so we can hone in on the growth in pregnant women and children groups for SFY 21.

Michael – Correct, I'll provide the risk group breakdown for this aggregate chart.

John – Any additional comments? CMS doesn't have any further questions.

Stephanie – As you're aware this was included as part of our response submitted yesterday. I hope this addresses CMS' questions but if there's something else you need, please let us know.

Alissa – We can decide how we want to use Friday call. We'll send out a hold for 3pm EST on Friday.

Gary – Our quality team may have a topic they'd like to discuss so we'll send that over.

Alissa – Great, go ahead and send that to us and we'll aim to get you our follow up questions by Friday.

TX-CMS Call on 9/10/21 Notes

Texas Attendance

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Gary – two topics: pay for quality (P4Q) discussion and consistent baselines.

Andy – provide a tiny amount of background: when talk about year over year improvement, we feel there is a need to recognize natural fluctuation in performance (below or above prior year). In our own state P4Q program (for medical and dental), we do this and provided a summary document to you of how it works. There is a set of quality measures in Medicaid and CHIP programs and use this methodology with these programs. Wanted to offer the opportunity to walk through the document to make sure you understand?

Laura – would appreciate your walk through of the document to make sure we're all talking the same language.

Andy – should start with a couple concepts. This is not a withhold payment. In instances of poor performance, we recoup monies that we have already been paid and for exceptional performance, there are bonus payment above what the MCO already received. For whatever we recoup, we reinvest those dollars into the bonus payments.

- There are two ways that MCOs can earn funds for one measure – if one measure is worth 25% of the pool (for instance), the MCO must improve against self and over the benchmark to get the

full amount. It is possible, for plan to just get one of the two components (i.e., recognize for performance against self but not benchmark). These two aspects are associated with each measure.

- Safety band for performance over self – as an example, 3% below and above from last year performance. If above 3%, have two levels of earnings. There is a minimum amount and to get full/maximum amount, need to improve much more than 3%. Size of the band varies by measure when look at performance from last year and benchmarks, look at this each year.
- Safety band for performance against benchmarks – there are percentiles on those benchmarks, based on state median and HEDIS 50th percentile. In the document, we explain that if state mean is below the HEDIS 50 percentile, the notion of safety band exists. To earn incentive dollars, the MCOs have to be above 50 percentile.

Does this make sense?

Laura – yes. Initial question – understand that the 3% is an example and that devising this percentage is data driven. What factors go into setting those bands?

Denbigh Shelton – look at spread of performance against benchmarks. Take top and bottom of spread for performance and put it in tiers. Reasonable to expect MCOs to move within those ranges.

Laura – that helps. When looking at top performance and bottom performance benchmarks, are you looking at past year performance?

Denbigh – on pg 2 where see colored boxes, for example - HEDIS 66% percentile = rate of 80% and bottom rate of 60%. So 20% spread so there would be 5% for each tier. Hopefully that provided you a more concrete example. These percentages for the safety bands are the same for all MCOs.

Jen M – understand that benchmarks are the same across MCOs, but is benchmark data available to isolate performance by MCO.

Denbigh - hold MCOs to the same benchmarks for each measure but do evaluate them individually. And recoup and reward individually.

Jen M – Andy, for safety band, how do you address low performers?

Denbigh – for improvement over self or improvement over benchmark?

Jen M – not sure. Does that threshold still apply?

Denbigh – safety band is applied equally across MCOs. Regardless of their performance. Sometimes hear complaints from plans that it is more difficult for high performers to demonstrate improvement. But that is why we do allow for payment when the plans perform over a certain benchmark too.

- For improvement over self – don't want to penalize a plan that is doing better than their peers but worse than national average (doing relatively well) – where the concept of safety band comes in. For plan performing below state average and performed more than 3% below than where they were last year, that would put them in recoupment range. If declined some but not more than 3%, and was performing at national average, would not recoup and plan would receive bonus payment.

Laura – we do have draft responses to share with state by end of day today and includes what we are thinking about in terms of safety band to account for the natural fluctuations in performance. There seems to be consistency between what once you've discussed here and our responses.

Andy – that feeds into our next point. We would not be able to use the same safety band methodology from the P4Q programs for the directed payments. There are ways to do aspects of it and it will take different amount of time to get there, etc. For QIPP, we took a look at this approach prior to year 5 submission, and we were not able to look at lower threshold as there were instances where a single resident could significantly throw off a percentage. Couldn't come up with a band like this for QIPP, which is why we came up with escalating benchmark approach. This wouldn't necessarily be the same case for the directed payments with other provider types.

Laura – it will be good for state to see our responses and would likely be a good topic again for next week once state has had a chance to review.

Gary – baseline conversation next.

Andy – CMS had previously identified that the state needed to set consistent baseline discussed. Turn to Emily for this discussion.

Jen – just want to mention that our forthcoming responses to the state get to this point as well.

Emily – look forward to receiving those responses – will be helpful to see. Did want to provide more context. We had a conversation with CMS in January and talked about providing context in the evaluation, particularly given the pandemic upheaval. During that meeting we had discussed using 2019 as the baseline.

Andy – there was a question that we sent to CMS about setting benchmarks each year vs at the beginning of entire program. There could be one answer when determining eligibility of payment vs evaluation of program. We're hoping that will be clear in your responses.

Jen – yes, we responded based on pay for performance vs evaluation. For P4P measures, baseline can be new each year but for evaluation purposes, should have one year that is consistent for baseline. We provided some examples of how that would work.

Gary – that concludes agenda for today. Does CMS have good news for us or should we start planning agenda for calls next week?

John – probably should plan for call on Tuesday. As you heard, we will be sending written responses by end of day today. That might be a good topic for Tuesday or if state has other agenda items.

Gary - we will discuss internally. Do CMS' written responses address the financial questions that the state had?

John – yes includes financial information. If there are other pieces misses, we can address that on Tuesday. Laura anything else?

Laura – no.

TX-CMS Call on 9/14/21 Notes

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Gary – agenda items: 90% cap for CHIRP and attestations in non-federal share

Tory – defer to CMS on which agenda item to start with. Thank you CMS for the written feedback. Start with attestations. For first section of responses on NFS focused on bond and debt instruments, we understand that CMS is not asking for that info right now. But looking for this information prospectively as we develop oversight plan. And CMS identified the 9 entities that we should start with in our oversight. Is that understanding correct?

Jeremy – yes that is correct.

Tory – want to share our new oversight director started yesterday.

Jeremy – if she has any questions, etc. as she ramps up, happy to connect.

Tory – her name is Francis Morgan and she is on today's call. Moving to the LPPF section of the responses, we were able to conduct the specific analysis you were looking for and will be providing a copy with our written responses back to CMS.

To previous our findings for CMS, we identified 28 operating jurisdictions with LPPFs and 26 of those were active. Did a comparison of paid assessments, and 24 of the 26 of operating jurisdictions did not

receiving Medicaid payment. For the two jurisdictions that did receive Medicaid payments, their Medicaid payments were substantially more than they would have received under the LPPF. In both cases, the state is confident that there is no relationship b/w Medicaid payment and amount paid into LPPF. They are two small counties: Ellis and McClellan. State feels comfortable making attestation that no causal relationship.

Rory – very helpful, we will take a close look once receive. Talked a lot about how IGT pooling works. In your written responses back to CMS, please be as clear as possible when defining it.

Tory – totally understand. That's helpful feedback. With relationship to last item in the written responses, the state appreciates the opportunity for state to attest that no hold harmless arrangements exist given the 600+ hospitals in Texas, and as some of them are very small, it is helpful to state to be able to do the attestation. We are preparing response. CMS had specifically identified 1903(w)(4) and 42 CFR 433.68(f)(3) as the applicable citations – the state plans to make attestation for all of (f), not just (f)(3). Okay for state to make attention on behalf of everyone?

Rory- just to be clear, looking for attestation that is supported by evidence that those agreements don't exist. Looking for attestation that these arrangements aren't in place and how the state determined this.

Tory – will need to confer with our leadership/counsel but that's helpful feedback.

Rory – appreciate the questions and if have any additional questions, let us know.

John – that concludes discussion for FMG?

Tory – thank you for the detailed questions on 90% cap for CHIRP. Wanted to note the reason there was one hospital missing b/w Att A and C is that one hospital was being listed twice. For the 90% cap, will be sending to CMS a revised model and the percentages increases for each hospital. Wanted to gauge from CMS if you thought that this 90% capping approach will be more reasonable to CMS?

John – we are still assessing that, don't have answer to that question yet.

Tory – do want to flag that there are some hospitals that under UHRIP are being paid at 100% of Medicare and would not be subject to 90% cap.

Laura – understand that 90% cap would apply to ACIA component. UHRIP would be paid out first, and then whatever remains would be paid out under 90% cap.

Tory – Exactly. If payments are made in excess of Medicare UPL, then cap is applied. For the 17 hospitals that did not provide ACR data to the state, we had originally asked CMS for 4 months for those hospitals to be able to provide this data. What would happen to those hospitals if they didn't furnish that data? Is CMS expectation to remove those participants from the program retrospectively or mid-year?

Laura – We were trying to understand what was state's plan would be for those 4 months to get the data. Our assumption would be that those hospitals would still receive payment in those 4 months.

Tory – can tell you verbally that our plan was that the 17 hospitals would receive payment during 4 months. We think the hospitals will be cooperative. State would do a mid-year adjustment based on the data provided. In the event that a hospital is not able to provide data, would appreciate being able to remove them prospectively from the program. Would like to avoid removing them retrospectively.

Laura – there is a lot of data to go through. Helpful to see the data around that.

Tory – is there anything you have questions about that we can discuss on today's call?

Laura – know we talked about this, but just to confirm: the 90% cap is inclusive of admin (premium tax, profit margin, etc.) components?

Tory – The cap is specific to hospital payments. Total program size $4.7B.

Laura – helpful to break that out for us in written responses – provider payments vs admin costs.

John – anyone from CMS have anyone questions? So sounds like state is working on written responses. Take a moment to talk about agenda for Thursday. Any topics know you want to cover or decide via email?

Gary – we will follow-up via email.

John – sounds good.

Texas meeting 9/14/21
John Giles, Rory, Amber,
Gary Young, Victoria Grady

attestations on NFS

- Victoria: you're not asking for information right now, but rather prospective, for developing the oversight plan. You (CMS) wants info going forward.
    - Jeremy: yes
- Victoria: New director, Francis Morgan, of local funds started yesterday. Item 3: next steps are underway so making progress.
- LPPF: able to conduct the analysis under Item 2. Will include it with written responses. Have 28 authorized jurisdictions. Only 26 were active in doing an assessment. Two were not fully operative in FY20.
    - Went through and compared paid assessments in FY20 to Medicaid ___. One provider did not receive $ to cover their assessment.
    - Two jurisdictions did not have that situation. But paid more than what LPPF would have permitted. Maid payments are not correlated. In both cases, based on our analysis, no causal relationship between Medicaid amount received and payouts from LPPF. It's
    - Ellis and McClennen county. Only two hosps in ea county subject to the tax.
        - Ellis: 28% more IGT would have been needed to receive. So funds coming from other sources
        - McClennen: 37%
- We will be reaffirming the attestation that no causal relationship between IGTs and LPPF.
- Rory: When you're providing the data, be clear about definitions of data.
- Victoria: opportunity for hospitals to attest. There are 650 hospitals. Some don't receive Mediaid payments. So it's helpful to have a singular attestation. Prepping response.
    - 1903(w) and 433.68. Will make attestation on all provisions of F, not just (F)(3)
    - Rory: that's a pathway. Not looking for just those two citations. Looking for attestation that's supported by evidence, that the agreements don't exist.
    - Victoria: will have to confer with counsel

TX-CMS Call on 9/16/21 Notes

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Agenda-

- CMS response to Texas' Sep. 7 letter
  - UHRIP amount
  - Timelines for UHRIP and QIPP
    - 45 day CMS notice for contract amendment
    - Provider reporting for QIPP
- Texas response to CMS' communication on Sep. 10

Stephanie – We submitted a response on September 7th and we wanted to talk about some aspects of it: 1) the UHRIP amount and 2) Certain timelines associated with QIPP and UHRIP.

Trey – We wanted to check in with you and see what else you still need from us for UHRIP amount. Last week we walked through the case load implications due to the PHE and the complications that created for UHRIP

Alissa – we have everything we need and are having internal conversations about the state's response but don't have an update today

John – We have all the info we need, appreciate the state providing the additional charts and data. Nothing pending from state, we're just working on internal discussion.

Stephanie – the second thing related to the Sept 7 letter that we wanted to discuss are some timelines we want you to be aware of. We will have MCO contract amendments and we usually submit these 45 days in advance but given our current discussions we're wondering if there's flexibility on that 45 days.

John – I do not have any concerns about the 45 days but let us take it back to MCOG to be sure. But there's no policy reason we can't be flexible.

Alissa – I agree, we will speak with MCOG.

Stephanie – For QIPP, there is provider reporting that begins in October so we wanted make sure you're aware.

Andy V – For awareness, we're working on launching this next year of QIPP in anticipation of approval soon for the preprint. But in the meantime, QIPP does have monthly reporting as a condition of program eligibility and that's Condition 1 under the CY 22 preprint. We are now requiring that they submit a performance improvement plan and report on progress so this first report is the first time they'll communicate to us on their PIP. Must submit report on 4th business day of everything month eg Oct 6. So there's some urgency for us to be able to work with those deadlines and to communicate next steps with our providers. Condition 2 also has reporting component, that's the staffing component so they need to let us know on monthly basis the total RN hours.

John – I don't have any concerns but let me ask the rest of the CMS team.

Stephanie – Our main point is that we'll need to communicate to those providers the expectations ASAP.

Alissa – Thank you, we appreciate that and it's helpful to have that reminder. We are actively discussing internally.

Stephanie – we can move onto next item. We provided responses to your communications last Friday. We wanted to talk through those responses.

Victoria – in the package you'll find responses to the questions or clarifications and you'll find a number of attachments. We've submitted revisions to all 5 preprints based on the items that have been under discussion and that we felt were ready:

- CHIRP – updated preprint and all related attachments that were impacted by 90% cap
- QIP – we made revisions to reflect the reconciliation discussion. We've included a graphic with timeline and process steps. That's applicable to all components privy to reconciliation discussion.
- TIPPS – we've made updates for reconciliation components in Comp 1 and Comp 2. We've updated the preprint make it a uniform increase and acknowledge the reconciliation component.
- BHS – we had initially checked that it was VBP but after talking to Laura we discussed that the it was a uniform increase and we'd like to discuss this further with CMS. Our issue is that we don't have baseline data for some of those components. We'd like to use this year to gather baseline

data with the understanding that this is an multi year effort. We were hoping to make collection of this data as a condition of participation.

- RAPPS – relatively minor updates but clear and consistent with communications

We wanted to see if you had any input or thoughts about data collection for TIPPS Component 3 and for DPP BHS Component 2.

Laura – I appreciate the overview and we haven't had chance to fully review responses. As for the baseline data, we do see other states with this issue e.g. it's not coming in. What states will do in the first year or two of the program is they will not pursue a VBP arrangement but instead, will use the first couple years to provide a uniform increase per service conditioned upon provider provision of data that can then be used in the future to establish baseline. With that data you could then gradually move to a pay for performance type arrangement.

Victoria – that's exactly what we had in mind for those components. We just didn't want to catch you by surprise. It sounds like we are on the same page and now that we've changed preprints to reflect that they're uniform increases and obligate providers to report on needed data in order to gather for a baseline.

Laura – yes, as long as the requirement applies to the entire provider class. Some things to consider are to make sure that they report on the Medicaid managed care population only and also be aware of the timing of reporting due to data lag so that it overlaps with your rating period.

Victoria – that's helpful. I also wanted to note on the source of the non-federal share that our preprints didn't require updates for that but rather we included that information in attachments. My quality colleagues also wanted to make some notes on the status of the evaluation.

Emily Z – We wanted to mention that we didn't make changes to evaluation in the preprint but added in the responses to questions. We had discussed doing one evaluation report vs one per preprint so we're focused on provider reported measures. We'd also like to modify to add provider reported measures. We do still want to use some state-wide measures but we've really decided to focus on provider reported measures. We do we want to hear what CMS thinks about that approach.

Jennifer M – Thanks for that, I did see in the responses that the state has included info about the evaluation plan. We're still reviewing those responses but per our discussion so far that sounds like a good plan. Are you planning on submitting a comprehensive evaluation plan in the future?

Emily Z – Yes, we're working on that for the future.

Emily S – You'll see in our responses that we took your direction and will be compiling the evaluation across the 4 new DPPs so we can maintain some state analysis but so that we can restrict evaluation to measures that can be attributed to participating providers and Medicaid managed care beneficiaries. We need to make some changes to the measures providers are required to report on. It'll take us some more time to sort that out. We should be able to get that out in next 2 weeks or so.

Jennifer M – that's understandable. Glad we have a plan and the state is moving forward.

Laura – one quick thing I forgot about QIPP, I can't remember if it's component 2 or 3 – one of those components is using historical adjudicated claims vs current claims. So, if you move to a uniform increase then it will require current claims.

Victoria – Component 2 for TIPPs takes a similar approach to reconciliation where we make interim payments and then reconcile at the end of the rating period to account for actual utilization.

Liz C - We took a quick scan of the state's quality responses and we need more time to review but thank you for walking through the responses with us.

Stephanie – Next call is scheduled for Monday and we can work up an agenda off line.

John – Sounds great

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Agenda:

- UHRIP program size
- 45-day filing issue
- Feedback on our revised CHIRP pre-print calculations
- Resolution on the 2 non-federal share LPPF attestations that were provided

John – first agenda item. UHRIP program size – just seeking an update from CMS or have any questions? CMS has reviewed additional information received from state. At a CMS staff level, do not have any questions for state. Just waiting for leadership feedback.

Gary – no questions from me.

Trey – no questions – just wanted to be sure have all information you need.

John – thanks, no additional information needed at this time. On 45-day filing issue requirement, understand that state had been operating based on a requirement to submit MCO contracts to CMS 45 days prior to start of rating period. Checked with 1115 waiver team and DMCO, and confirmed 45 day

requirement (whch had been an old STC) was eliminated in 2017. No need to provide flexibility b/c that requirement is no longer part of your waiver.

Gary – anyone from legal have any questions?

Megan – nothing from me.

Gary – think we would construe that as good news. Can we get an email with this in writing?

John – think so? Alissa? Any concerns?

Alissa – yes we can memorialize this via email.

John – will send email today. For third agenda item, anything the state wanted to tee up?

Gary – defer to Victoria.

Victoria – no initial questions, just wanted to see if CMS had any questions?

Laura – going through data that the state submitted. With 90% cap being just on ACIA, we did have a question since there was one class for UHRIP were there was a change. We compared the percentages increases provided to Rnd 3 responses (Att C) and compared that to what was sent last week.

Victoria – happy to check on it. Made sure using most up to date UPL.

Laura – Thanks, we were not expecting to see any changes for UHRIP. Also a higher level question, at a class level, UHRIP payments will go up to Medicare UPL and then the 90% cap would apply to ACIA. For hospitals participating in only UHRIP and not ACIA, we had understood that there are 106 hospitals that would be receiving payments for inpatient services above the average commercial rate and 83 hospitals for outpatient services. Are these numbers still accurate?

Victoria – yes, those numbers still should be accurate.

Laura – most of the drop was in ACIA components, but also saw decline in fees (risk margin, admin, and premium tax).

Victoria – yes that is correct. Tied to decrease in provider rates.

Laura – also noticed that for rural hospitals, did not see much of a decrease for inpatient but did for outpatient. Does the minimum fee schedule requirement for rural hospitals play a role here?

Victoria – fee schedule applies to both inpatient and outpatient services, so no impact there.

Laura – we have tended to see for most classes that when they qualify for inpatient increases, tended to qualify for outpatient increases too.

Victoria – one thing to keep in mind – rural hospitals have small inpatient delivery. Outpatient service delivery is more critical.

Laura – also noticed that several hospitals for urban SDA (think the larger SDAs) got a little more of a hit than the smaller urban SDAs.

Victoria – yes, saw that too. Houston for instance.

Laura – Harris county?

Victoria – Yes Houston is located in Harris.

Laura – for the maximum percentage increases, still showing some 4-digit percent increases for some classes. Know we can trace back to data – but is there anything you can share for these?

Victoria – yes, there definitely are still some outliers. We are doing our programmatic due diligence and thinking through whether some of the underlying data requires further investigation. Large part of this is that many of those hospitals have little Medicaid utilization. Was initially surprising to us as well.

Laura – with QIPP, know there is a requirement for NSGOs that they can only receive payment if provide care to certain number of Medicaid beneficiaries. Has the state considered a similar requirement?

Victoria – could think about that for future. Challenging with rural hospitals as don't have high percentage of Medicaid delivery but doesn't mean they are not financially vulnerable.

Laura – completely understand – just something that came to mind re: program requirements in the state's other directed payments for low Medicaid utilization.

John – before move on, anything else Victoria?

Victoria - will get back to you on question re: Hidalgo IMD SDA today.

John – last agenda item, turning to Rory.

Rory - thank you for the information provided. We should have follow-up questions in the next day or two. Anything you wanted to lay out for us?

Victoria – just wanted to see if there was anything we can help answer.

Rory – I can give you a flavor of our questions. On first issue related to tax structure for localities, will have some technical questions based on what we're seeing on tax collection. Some additional LPPFs – 4 instead of 2 that are receiving tax back. Couple questions like that – instances when locality imposing a tax where all tax payers are receiving tax back via increased Medicaid payments.

Victoria – as to the 4 localities, the additional two are for Cherokee and Oasis. And for those, they were not active (i.e., had not assessed taxes).

Rory – got it. Just may ask for that in writing. For second issue, on attestations, largely where we been –. don't know that I fully understand what the state means –i.e., what the state did to come up with this attestation and what that means from state perspective. Still may have concerns – don't really know what's happening with agreements and how this might change that with this attestation. That's the nature of the questions you'll see.

Victoria – understood. Look forward to seeing those questions. Should see those in next day or so.

Rory – think that's it from us John.

John – Thanks. We'll send out an invite for Wednesday and the state can send us via email any agenda items.

TX-CMS Call on 9/22/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	D Dillon	Evan Dial
Rachel Butler	Michael Ghasemi	Denbigh Shelton
Trey Wood	Stephanie Tourk	Courtney Caruthers
Joelle Jung	Emily Zalkovsky	N Boston
Linda Hunyh		April Ferrino
A Campbell	Joey Reed	Frances Morgan

CMS Attendance

Daniel Tsai	Layla Fraser	Jennifer Clark	Tom Caughey
Ann Marie Costello	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
John Giles	Allison Weaver	Charlie Arnold	Carrie Smith
Laura Snyder	Elizabeth Clark	Jonathan Endelman	Norina McAuliffe
Juliet Kuhn	Christopher Thompson	Andrew Badaracco	Michelle Beasley
Eli Greenfield	Jeremy Silanskis	Richard Cuno	Daria Romanov
Diona Kristian	Jocelyn Velez	Deborah McClure	James Burns
Shamberkia Wise	Tamara Sampson	Jennifer Maslowski	Amber MacCarroll
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Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Gary – only agenda item is approval status of SDPs. To that regard, begin by talking about UHRIP and deadlines around that. Would necessitate approval by end of this week. Need determination of program size.

Victoria – talk through timeline for UHRIP.

- Waiting for confirmation of what the program size could be and if can be retroactive to Sept 1. Need to put in contract amendments and submit preprint documentation.
- Also need to undertake state rulemaking – b/c rules currently had UHRIP ending for last rating period. If the state got confirmation from CMS by Friday 9/14, rules would be published in mid-October and with state public notice and comment requirement, adoption would be by mid-November.
- Contract changes would take effect mid-November. Appreciate that don't need to consider the 45 day prior submission timeframe.
- MCOs will need make changes to revert back to UHRIP in their payment systems – to restart URHIP, will take 60-90 days for these system changes so Dec or Jan 1. MCOs would also need to do claims reprocessing. Anticipate that process would start in Jan.

- All in all- if get confirmation by this Friday and all those processes started to be put in place next week, 3-4 month process before funds go out to providers. Wanted to share b/c know CMS is working on a response.

Gary – really appreciate information collection to date. Know you said at staff level, no further questions.

Alissa – really appreciate the information provided by state. Have information we need for Option 1. As to Option 2, we are looking at the information and discussing internally. Don't have any further update.

Laura – FMG is close to finalizing written responses and anticipate sending those by end of week. Also gathering questions from other FRT members, but know there will be some questions on NFS.

Gary – Texas team, any questions for CMS?

Andy – question related to QIPP. 2 approaches before you – what we originally submitted and newly submitted based on utilization changes. not sure if you are reviewing one or both.

John – primarily reviewing the latter – the more recent version.

Brittani – For the NFS questions, are there any that remain for Option 1?

John – we can confirm that with our FMG colleagues.

Gary – I don't have any other questions.

John – hoping to send question by end of week but will confirm with FMG.

TX-CMS Call on 9/24/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	D Dillon	Evan Dial
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Alexis Gibson	Rebecca Burch Mack	Mara Siler-Price	Anna Bonelli
Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Gary – full complement of staff available to answer any questions about the email the state sent CMS on September 22nd.

Alissa – want to start by saying, CMS and the state do not have yet have an agreed upon path. If CMS and Texas were to proceed with option 1 as outlined in CMS' letter to the state on August 13, 2021, in which we would grant approval of UHRIP after the pre-print is submitted retroactive to September 1, 2021, we would approve the methodology outlined by the state in its 8/27/2021 email. Under this methodology, the uniform increases remain the same as of 3/1/2021, and the aggregate amount of the SDP paid under UHRIP would vary by caseload such that the final aggregate amount could go up and down based on actual member months. Happy to put that in writing if that would help the state with their programmatic needs.

Gary – does staff have any questions?

Alissa – I know Dan and Stephanie having been having conversations too.

John – in addition to FMG questions, we will have questions from FRT members and antcipate sending those all to you today.

TX-CMS Call on 9/24/21 Notes

Gary – I don't have any questions.

Alissa- we can use Tuesday to go over questions that CMS sends today.

Gary – also want to follow-up with you on QIPP next week.

Stephanie Tourk – if there are any conditions that go along with what you stated upfront, please include that in email that send to the state.

Alissa – want to clarify that we find the UHRIP methodology approvable. Not agreeing upon path forward.

Tourk – are the other 5 preprints still pending?

Alissa- yes, b/c don't have agreed upon path, those are still pending.

Gary – appreciate you time.

Alissa- will follow-up with the state via email after this call.

TX-CMS Call on 9/28/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	D Dillon	Evan Dial
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Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

- Check-in on the status of the September 7th Letter.
- Review the list of items/issues described by CMS in the August 20, 2021 preprint modifications discussion document to validate whether CMS considers each item to be open or closed, and if open, what additional information is needed.

1 QIPP 1. Reconciliation
2 QIPP 2. Quality/Conditions of Participation
3 QIPP 3. Evaluation
4 CHIRP 1. Aggregate Amount
5 CHIRP 2. Evaluation
6 TIPPS 1. Reconciliation
7 TIPPS 2. Quality/Conditions of Participation
8 TIPPS 3. Evaluation
9 RAPPS 1. Reconciliation
10 RAPPS 2. Evaluation

11 BHS 1. Reconciliation
12 BHS 2. Quality/Conditions of Participation
13 BHS 3. Evaluation
14 NonFed Bonds 1. State Attestation
15 NonFed Bonds 2. Assurances
16 NonFed Bonds 3. Oversight Plan
17 NonFed LPPF 1. LPPF Amounts
18 NonFed LPPF 2. State Attestation
19 NonFed LPPF 3. Local Attestations

- Review any questions we may have resulting from the items we just received from CMS.

Gary – what is the status of CMS' review of Sept 7 letter?

Alissa – still pending leadership discussion.

Gary – appreciate that. Next, want to run through – 19 outstanding items from CMS' original Aug 20 document. Talk about the issues by group so first, talk about reconciliation, any outstanding issues?

Laura – we did include some technical questions about reconciliation requirement in the Friday questions that were sent to the state. Anything that would be helpful to walk through? Reconciliation cuts across 4 proposals.

Tory – CMS' response on Sept 10th indicated that the approach was consistent with regulation – so just want to confirm that we can use this approach and CMS is just trying to get more clarification/detail about the specifics.

Laura – yes, making sure information is understood and captured in preprints. Making sure in particular in we understand how it will be captured in rate certification.

Tory – yes that makes sense, thanks.

Gary – next – quality/conditions of participation.

Laura – really relates just now for QIPP b/c other proposals that had conditions based on quality/performance, are now based on utilization. Correct? Just wanted affirmation.

Tory – yes that is right.

Andy – yes that is correct. Rate enhancement only. Ask for clarification about language: Condition of participation vs eligibility – is there a distinction?

Laura – don't know we have a distinction, provider would have to demonstrate certain level of performance in order to be eligible to earn payment = condition of eligibility/participation. Really a matter of how you define provider class and who would be eligible to receive payment –rather than basing payment upon performance.

Andy – that's helpful. In talking about condition of participation, we talk about that as continued reporting by providers vs eligibility as to the requirements that providers must meet prior to the start of the program year.

Emily – state articulated for the 4 new SDPS, when discussed last Wed, clarified that state would be reflecting it as rate enhancement and reporting would be a condition of participation.

Laura -rate enhancement will still be based on current utilization. There may be a requirement at beginning of year that there is a reporting requirement that could make them ineligible for payment if don't participate. Just wanted to confirm that payment is based on services (in acknowledgement that providers are will be required to report data).

Gary – next item is Eval.

Andy – in eval, set a target for eval and previously discussed, for year 1, still about collecting baselines so wouldn't include baselines in eval plan. For year 2, wouldn't have all baseline data but could start setting bar. Bar will be blind until have data.

Jen – makes sense. In Year 2, would want to revisit with you – know you may need to adjust. That is our understanding. One question for you – in one set of responses, talked about how SDPs are focused on Medicaid managed care benes and the challenges for some providers to in reporting this data. Was not clear if these were challenges (stratifying for Medicaid managed care benes) but state will work to overcome?

Emily – yes, system changes for some providers needed. Some providers can do this now and will require that this reporting happen now. Intent is to stratify by Medicaid managed care.

Andy – for QIPP, will not be able to do that for SFY 2022. Gets into prior conversation about pulling raw data. Requires system changes on state part so working on that for SFY 2023, looking at cost/time.

Jen – some providers will be able to report by Medicaid managed care benes for the other 4 other SDPs for SFY 2022, and not for QIPP.

Gary – CHIRP aggregate amount. Any outstanding information needed from CMS

Laura – technical questions in last set of responses – so have full picture and put in writing. Still evaluating information provided and assessing. Responses to technical questions will be helpful.

Tory – for continued review, curious if discussions are more technical in nature or about underlying methodology? Still having philosophy discussion?

Alissa- all of the above.

Gary – NFS issues. State attestation.

Rory – for bonds issue, I don't think we have additional questions. We have not conducted a full review of each arrangement. Focus has been on state oversight. Cannot provide a blanket statement on approvability. Remaining questions do remain on LPPF.

Tory- what I'm hearing, for purpose of SDP review, the bond issue can be considered close. Doesn't preclude CMS, OIG or other inquiries.

Rory – caveat it that it just a staff level review, we need to discuss everything with leadership.

Tory – 3 distinct outstanding items. No remaining questions on the first item, and had follow-up on the two items.

Rory – yes that's fair. Any clarifying questions for CMS?

Tory – have been doing information gathering on the question: Can the State please explain why four of the LPPFs listed in Attachment B were assessed mandatory payments in which all the hospitals received Medicaid payments in an amount greater than or equal to their tax burdens (for Ellis, Nueces, Cherokee and McClennan Counties)? Some information on collections process/ delinquent tax paxers. Or hospital was new so weren't collecting revenue to base hospital assessment.

Gary – last agenda item, any questions from Texas staff? Planning to send responses back to CMS tomorrow.

Alissa – next meeting scheduled for Thursday? Walk through the state responses on Thursday would be helpful.

Texas State Directed Payment Discussion 09/28/2021

Gary Young from Texas led the call. Alissa and Laura addressed some of the Utilization and payment issues with the preprint. They also addressed quality and evaluation

Non-Federal Share

Rory provided information on the bond question. We do not have any additional questions on the bond issue, but this does not mean we will not revisit it. As for the LPPF arrangement, the state said they are in discussion with the counties on the 36 hospitals that are in a delinquent tax issue or may be a new hospital to the group. They will send us the information tomorrow. The next meeting is Thursday. SDG will walk through the state's responses from Wednesday.

TX-CMS Call on 9/30/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	D Dillon	Evan Dial
Rachel Butler	Michael Ghasemi	Denbigh Shelton
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Joelle Jung	Emily Zalkovsky	N Boston
Linda Hunyh	Erin Cibrone	April Ferrino
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CMS Attendance

Daniel Tsai	Layla Fraser	Jennifer Clark	Tom Caughey
Ann Marie Costello	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
John Giles	Allison Weaver	Charlie Arnold	Carrie Smith
Laura Snyder	Elizabeth Clark	Jonathan Endelman	Norina McAuliffe
Juliet Kuhn	Christopher Thompson	Andrew Badaracco	Michelle Beasley
Eli Greenfield	Jeremy Silanskis	Richard Cuno	Daria Romanov
Diona Kristian	Jocelyn Velez	Deborah McClure	James Burns
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Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Gary – start with state's responses.

Alissa – outstanding modifications list received via email yesterday. Will go through list and respond via email to confirm status.

Gary – yes, also sent in yesterday the state's response. Can walk through the responses.

Tory – a lot of questions on reconciliation were repeated, so repeated responses. In terms of 3 processes, we noted that do not plan to change MCO rates unless rates are later to not be actuarily sound. Most communications b/w state and MCOs are through a provider scorecard, so would be done through that. Confirmation request under question 9.a. about payment amounts. Due to administrative complexity, therefore state prefers this vs as claims are adjudicated. State recognizes this is administrative burdensome, b/c of changes to MCO coding system – able to operationalize this much more quickly. Definitely a consideration for future years but willing to accept the additional burden for this year.

Laura – appreciate that feedback. This structure is unique – reconciliation is usually tied to service, which is why we had so many questions. For the payment scorecard, is that reviewed as part of MCO contracts that CMS reviews?

Tory – exists outside of contract but contracts references it. Scorecard has existed in QIPP historically – stand alone Excel document. We use this tool to notify plans via Excel to make any adjustments as payments. Process familiar to Star plus plans. For other SDPs, could use same tool for reconciliation.

Laura – we also wanted to confirm that these SDPs would be an adjustment to base rates? Versus as a separate payment term. Given complexity, wasn't sure if state needed to move to separate payment term.

Tory – stay as adjustment to base data.

Laura - another complexity, will there be a requirement that the plans hold a certain amount of the PMPM for directed payments?

Tory – no, payments to plans will be ongoing.

Layla, OACT – question regarding final reconciliation and potential adjustment to rates. State said in responses that there may be adjustment to rates if rates found to not be actuarily sound. What would trigger an amendment?

Rachel Butler – we're looking at imbalance in terms of scorecard; one MCO be required to pay out significantly more than what received during capitation rates. Looking at it more as a shift should distribution be skewed among MCOs due to reconciliation. So any imbalances are corrected.

Layla – would this analysis be performed at a rate cell basis or at an aggregate?

Rachel – need to take that back and discuss with Evan but can get back to you.

Layla – do you have a threshold in mind? How different would actual utilization be to historical utilization.

Rachel – good benchmark would be something in excess of risk margin. Could look at MCOs, many operate in different regions. Could take a holistic approach – depends on situation but risk margin (1.5 1.75%); tough to say until we see it.

Layla – have any sense of how likely an rate amendment would be?

Rachel – I don't have a specific sense – a lot of uncertainty. A number of factors – tough to answer.

Layla – if there was to be a rate amendment, would the risk margin still be included that is associated with the SDPs?

Rachel – depends on how well we can hone in with the reconciliation.

Layla – that is all of my questions, thank you.

Rachel – will follow-up with Evan after this call and see if can get you anything more specific.

Laura- in interest of time, move on to other questions.

Victoria – move to non-federal share, I see Rory. Related to first response, 9 the facilities are Cherokee or oasis county (had authority but didn't tax, not in operation). 3 of them were blank rows. 5 of them are subparts of hospitals – really one entity and parent entity paid full amount. 7 were duplicative

TPIs/TINs. 12 facilities remaining. Clarity Child Guidance Center – that facility doesn't meet definition of provider who provides inpatient services and therefore don't meet definition and erroneously included. In other cases, the taxpayers were delinquent. A couple of facilities who are brand new and there wasn't data for assessment. Hopefully this data brings this issue to resolution.

Rory – take a closer look but that's exactly type of info we're looking for.

Victoria – related to jurisdictions who didn't receive full amount back. No correlation b/c amount facilities paid and amounts received under Medicaid program. Amounts received were considerably in excess. Reiterated in responses that no hold harmless arrangement exists. Last big item we provided feedback on, provided a written lengthy response – position is that we can attest on behalf of local governments. Regulation does not appear to extend beyond interaction between state and local government entities.

Rory – we have made our position known. Think the information we asked for is crucial. With that said, will take a close look at what you provided. Appreciate what you have walked through.

Laura – maybe QIPP and eval can be topics for Monday call.

Andy – yes that makes sense, take a look at responses and can touch on next call.

Gary – hoping things go well on hill and no shutdown.

Texas 9/30/21

- For 36 facilities identified for nonpayment
  - 9 cherokee or nuasis county. Didn't assess a tax (had the authority but didn't assessed)
  - 3 were blank rows
  - 5 are sub-parts of hospitals. They are really one entity. The parent entity paid full amount
  - 7 were duplicative, duplicate TINs
  - 12 remaining
    - Clarity Child Guidance: confirmed with gov't entity: doesn't meet def of providing inpatient care according to 42 CFR 440.10
    - Others: taxpayers are delinquent
    - New facilities: no data on which to base an assessment because it's levided based on net revenue from prior period
  - Where entity didn't get any amount: no correlation between amount facility paid and amount received through Medicaid program.
- Re attestation of no hold harmless. Fed law allows us to attest on behalf of the state. Reiterating and include as part of plan for ongoing monitoring. WIll include info for local gov'ts to certify. Reg doesn't extend beyond units of gov't and their providers.

TX-CMS Call on 10/4/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
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	Rebecca Burch Mack	Mara Siler-Price	Anna Bonelli
Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

- Discuss Evaluation
- QIPP quality
- Review and confirm open/closed modifications items
- Discuss HHSC's last round of responses to CMS 9/24 document

Laura – first agenda item is evaluation. Anything specific want to discuss?

Emily S – wanted to reiterate what we said in our most lastest repsonses. Consolidated eval into one eval but each SDP will be separated out. Back up and say and this is 4 new proposals, not QIPP. Each will be evaluated using provider only metrics and will be limited to Medicaid managed care data. Still doing a state level evaluation and will be at Medcaid managed care level and data not attributed to specific providers. Focusing on outcome masureas with baseline of CY 2021. Final thing working through is setting goals – b/c still CY 2021 data, won't have goals in this eval plan but will include goals for SFY 2023 and that would be subject to an amendment once we have 2021 data. That's everything that would see in evaluation plan.

Laura – make sure understand last part. Would not have anything for goals for this year but would be included in preprint for SFY 2023.

Emily – yes, anticpate getting data two times this year – so would have prelim data to establish goals and then would have final data after submission of SFY 2023 preprint. So would want to update goals in the preprint/

Laura – when do you typically get the final data in?

Emily – for provider reported measures, anticpate 2 reporting periods and having data in spring time for 2022 (3rd quarter of program year). Would have CY 2021 provider data by then. State level data from EQRO takes longer until Oct 2022 for CY 2021 data. So in those instance, would go with the 2020 data.

Laura – helpeful to have expectations for when data and how might affect preprint review process. Sounds like preprint data might be ready for intitial submission in spring 2022 and then state level data would come with a preprint amendment.

Emily – yes. In terms of reviewing and compiling, late spring/early summer for submitting amendment.

Laura – any questions Jen?

Jennifer – baseline data would be delayed to gather data. October timeframe for baseline data for 2020 – would that data be available in October 2022?

Emily – yes, that is the state level data (data not attributable to SDPs). Provider data antipcate being available in spring 2022 b/c providers will be reporting directly to us. Delay that were speaking to before, some providers will not be able to limit to managed care benes only. But that will not delay collection of data. Will have to see what impact is for providers but should be able to set targets.

Jennifer – speak about delay…

Emily – hopefully get all provider reported data for program year 2023. State level data – not a way to attribute it – pulled that out of the eval plan (HCAHPS surveys for instance, but still feel that there is value in looking at that).

Laura – unless anything else on first agenda item, can move to next item.

Andy – on QIPP, its minimal. QIPP is going to have its own eval plan and not rolled into comprehensive eval plan. Response clarified that we are going to modify how we prevent declining preference as an allowable variance in national benchmark.

Laura – that's helpful to summarize. Separate eval for QIPP is b/c of the nature of the program?

Andy – correct. on not rewarding performance when there is a decline (Comp 3) – to just dinsitnguish my 2nd point.

Laura – yes, for facilities declining in performance, state will allow for natural fluctuation but still prevent payment when there is notable decline. Confirm that this is for Comp 3 only?

Andy – defintely Comp 3, and component 2 maybe? but not really since Comp is met/not mmet measures so does not lend itself to that. Component 4 we look at measurement only once and it is already built in.

Laura- Comp 4 – focused on infection control, facilities have to perform better than baseline. We were a little concerned that learnings from Comp 3 could apply to Comp 4. Is that your understanding or is there difference?

Andy – Comp 4 on MDS measures is where comparing to performance they were last year as compared to basliene.

Laura – it is automatically improvement over self. Only improvement over self, correct?

Andy – correct. Looking to my team to see if I have corrected anything.

Laura- any other question on QIPP portion from CMS?

Gary – next agenda item on open items on modification list. Turn to Brittany.

Brittany – quickly go over remaining list. Covered eval for 4 programs but also have aggreagate amount for CHIRP outstanding. Any questions on that piece?

Laura – on last round of questions, were there any change to Att C or was that included just so we have final version?

Tory – just updated tab headers only. No change to substance.

Alissa- in going through list from Gary, we need a little more time to go through templates that you have submitted and evaluated them for completeness. Hestitant to be more firm here just need a little time. Laura, anything you would add?

Laura – that's correct, just want to be sure that nothing is missing or inadvertely missing.

Alissa- FMG questions forthcoming on Wed or Fri.

Gary – any comments or questions about out responses to your 9/24 document. Previous now or wait?

Alissa – prefer to wait until Wed. so Laura, maybe we can identify particular areas to go through for Wed.

Alissa – as always, will work to schedule that appt offline. and can add other items and will work to schedule the call for no later than tomorrow.

TX-CMS Call on 10/6/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	D Dillon	Evan Dial
Rachel Butler	Michael Ghasemi	Denbigh Shelton
Trey Wood	Stephanie Tourk	Courtney Caruthers
Joelle Jung	Emily Zalkovsky	N Boston
Linda Hunyh	Erin Cibrone	April Ferrino
A Campbell	Joey Reed	Frances Morgan

CMS Attendance

Daniel Tsai	Layla Fraser	Jennifer Clark	Tom Caughey
Ann Marie Costello	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
John Giles	Allison Weaver	Charlie Arnold	Carrie Smith
Laura Snyder	Elizabeth Clark	Jonathan Endelman	Norina McAuliffe
Juliet Kuhn	Christopher Thompson	Andrew Badaracco	Michelle Beasley
Eli Greenfield	Jeremy Silanskis	Richard Cuno	Daria Romanov
Diona Kristian	Jocelyn Velez	Deborah McClure	James Burns
Shamberkia Wise	Tamara Sampson	Jennifer Maslowski	Amber MacCarroll
	Rebecca Burch Mack	Mara Siler-Price	Anna Bonelli
Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

- QIPP Component 4
- Discuss HHSC's last round of responses to CMS 9/24 document

Laura – do have some follow-up questions based on responses and QIPP Component 4.

Gary – Andy had a clarification that he wanted to raise too.

Andy – realized pretty quickly after last call that Component 4 is structred differently than Component 3. For Component 4, only required to exceed benchmark. No improvement over self aspect.

Laura – yes, that was the same thing we were going to raise. Can the state discuss rationale for applying the same threshold for Component 4?

Andy – focus had been on Component 3. Were not ready to introduce both changes for this fiscal year. For next year, much more being contemplated but did want to feel you out on CMS' position.

Laura – B/c concerns raised from OIG aaround Comp 3, is there a reason there isn't a similar concern for Component 4 (i.e., significant decline in performance but still receiving payment)? Does that make sense?

Andy – we thought we were closer to agreement with CMS on this SPP and given where we are in the calendar, didn't want to take that on. More changes we make for this fiscal year – from a provider standpoint, will not be an easy change. Methodologically, it is doable.

Laura – what is the challenge from the provider perspective?

Andy – we do have the data (that what makes it doable).

Laura – so it is doable but provider fatigue is more of concern?

Andy – since QIPP is more established and part of Option 1, providers thought we were closer on approval. Also since August, we have been been talking about changes with providers and much more prepared for major changes for year 6. Providers are aware of CMS' concerns – they would be accepting of it but provider fatigue is good way to put it. If you recall, we had explored this for year 5 but hadn't been abel to come up with a solution. Even for Year 5 will have a cut off for performance declines.

Laura – helpful to hear what conversations are being had. Curious, during this year's review, we had noted that many of providers were already achieving the measures – has retiring or adding new measures been part of the discussion for year 6?

Andy – yes definitely. Part of discussion too is eliminating NSGO components. Once do that, opens up the structure in few ways. But don't want the program to explode.

Laura – one of area of concern is when a majority of providers are already satisfying a measure, we want to see improvement.

Stephanie – that has been general approach, to evolve programs over time. How we have evolve going forward is difficult to say given where we are in the calendar and that we don't have approvals yet.

Laura – thanks Stephanie, we definitely appreciate that. Only other question – does the preprint address the natural flucutaiton margin?

Andy – language about natural fluctuation is in the preprint. Did have one other question – if we are putting a hard floor on decrease, could that take the place of the escalating benchmark approach? Or do we need to do both?

Laura – we will want to bring that back to DQ, but understand two ways to get at the OIG finding. We think we would be okay with just the natural fluction margin and not the escaling bechmark, with the margin seeming like the better way to address the concern.

Andy – that has become loud and clear to us. So you will see both in the current preprint now but did want to check with you on.

Laura – for threshold for improvement over self, would that apply to facilities currently below the benchmark? Or just those that are above the benchmark currently?

Andy – only to facilities above the benchmark. Yes, we were thinking about including two tables in the print – improving over self vs over benchmark. But if any decline, have to exceed benchmark. Thought that might be cleader. In discussion about data, would CMS be ok using an absolute difference for the margin for determining payment (which is done quarterly) and then using percentage difference for the evaulation (which would be on an annual basis). Understand if that is too weedy, but wanted to see if had any initial reaction.

Laura – happy to take that back to our DQ collegues. Think that's everything we had related to Component 4. Any else on that front?

Andy – No.

Gary – No.

Laura – other agenda topic was feedback on responses.

Gary – curious if FMG collegues had any comments? Don't see them here so maybe can bring them in on Friday.

Alissa – yes we can do that.

Gary – that would be great. Anything else Texas? Guess we are good, Alissa.

Alissa – we will be in touch for times on Friday.

TX-CMS Call on 10/8/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	D Dillon	Evan Dial
Rachel Butler	Michael Ghasemi	Denbigh Shelton
Trey Wood	Stephanie Tourk	Courtney Caruthers
Joelle Jung	Emily Zalkovsky	N Boston
Linda Hunyh	Erin Cibrone	April Ferrino
A Campbell	Joey Reed	Frances Morgan

CMS Attendance

Daniel Tsai	Layla Fraser	Jennifer Clark	Tom Caughey
Ann Marie Costello	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
John Giles	Allison Weaver	Charlie Arnold	Carrie Smith
Laura Snyder	Elizabeth Clark	Jonathan Endelman	Norina McAuliffe
Juliet Kuhn	Christopher Thompson	Andrew Badaracco	Michelle Beasley
Eli Greenfield	Jeremy Silanskis	Richard Cuno	Daria Romanov
Diona Kristian	Jocelyn Velez	Deborah McClure	James Burns
Shamberkia Wise	Tamara Sampson	Jennifer Maslowski	Amber MacCarroll
	Rebecca Burch Mack	Mara Siler-Price	Anna Bonelli
Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

- Discuss HHSC's last round of responses to CMS 9/24 document – source of the non-federal share

John – my understanding is what we wanted to talk about NFS issues. Touch base on those responses.

Laura –we have collegues from FMG on. Not sure if you have specfic questions for CMS?

Victoria – see if CMS had formulated your questions and see if there is anything that would be helpful to talk through,

Rory – we are pretty close on your questions for you, should have something for you next week. Thank you for information provided on all different tax structures. It is a lot of information for us – looking at 20+ is a lot. Usually look at just one tax structure from a state. Has been very clear at this point. May have some questions for those 2 localtlies where taxpayers receive all the tax monies back. Still have overaching concern re: pooling and redistribution of payments. Do understand that cannot compel entities to provide information but may ask, if willing to share, for information related to these

arrangements that is publicly available. Give you a preview of where we're headed in our questions back to you.

Victoria – in terms of progress at state level, wanted to share some immediate next steps for state oversight. Director has now hired 2 managers and accepting applications for analysts. Hoping to do state wide oversight rule making – planning for Dec 1 publication for comment. Did want to let you know that we are continuing to work on those plans. Can be sure to share to share that rulemaking documentation with you.

Rory – that would be great.

Victoria – don't think I have anything else.

Gary – what about attestation issue?

Vic – thanks Gary, it would be helpful if CMS had any feedback on this. Actively working with our IT folks to build a system for this. Don't collect anything right now from private entities – so right now only thing that we have to rely on is state statute and local governments.

Rory – we'll look back at the latest attestation language that the state provided.

Alissa – next meeting will be on Wednesday, given the Columbus day holiday on Monday.

Gary – enjoy your weekend.

TX-CMS Call on 10/13/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
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Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Gary – we wanted to go over list of modification items and give you our sense of what is still open. Know we also submitted some QIPP documents. Turn it to Brittani on the modification list.

Brittani – submitted QIPP revised documents today. So that's in your inbox. That was in response to Laura and Andy conversation last week. And evaluation is still outstanding on our list and should have better update for you soon – have a meeting right after this on that. And then CHIRP payment amount is still outstanding and non-federal share are still outstanding.

Alissa – yes CHIRP and NFS are still outstanding. Having policy discussions internally. Laura and John, anything else?

Laura – I don't think there is anything else.

John – those are the 4 outstanding things that I was tracking as well.

Alissa – we will be following up with anything else in writing.

John – yes, no later than COB next Monday, will have any further feedback to provide you in writing. And make sure that whatever Rory has, will be included.

Gary – anything else from us?

Laura – re: the Component 1 that involves reconcilation that cuts across multiple proposal. State has indicated it will be adjustment to base rates. Wanted to raise question of whether it is more appropriate to incorporate into the rates as a separate payment term, since intent is to target a specific dollar amount. Could we talk through that a bit? Have the right staff?

Victoria – think we need to have out chief actuary, Rachel Butler, and probably your OACT on as well. Our actuaries have felt comfrotable with the approach. If concern is about actuarial soundness, then will want to pull in actuaries.

Laura – happy to have that discussion. Big portion of this is because when states try to target a particular dollar amount, we often see states use a separate amount term b/c of challenges in trying to get to that specific amount with adjustment to base rates. Want to be sure we understand how it will work.

Victotria – what we've tried to explain in our written responses is the difference between what we anticpate vs what may happen. Doing our best to forecast the year ahead with utilization given COVID and its unpredictability.

Laura – am I thinking about it correctly that there is a total dollar amount trying to hit for Component 1?

Victoria – fair to a point. There may be fluctuation – what we estimate what QIPP could be vs what is worth depending on caseload.

Laura – would state be opposed to looking at SPT for Component 1?

Victoria – we can have a more detailed discussion and get our external actuary on the phone. But preference would be adjustment to base rates.

John – how about this - we draft up a question to this extent, run it by OACT, and then include as part of the question set that is sent to you on Monday. And then we have a conversation early next week.

Victoria -sounds great.

Alissa- anything else? Just logistics, I will be out on Friday and all of next week so John will be handling the agenda and coordination.

John – maybe call on Friday we can walk through QIPP submission that was sent today?

Gary – that sounds great.

TX-CMS Call on 10/15/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
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CMS Attendance

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Agenda:

- TX updates for QIPP submitted on 10/13

Andy – in agenda/email for today's call we identified what has changed per QIPP component. Anywhere specific you want to focus?

John – do you have preference for how we proceed, Laura?

Laura – maybe focus on bigger changes.

Andy – one thing to note in preprint, there is table that specifies goals and objectives – we did update this. Hadn't done that in previous versions since we revised our QS. Just mention that because when you look at eval plan (Att I), it looks like there are a lot of changes but really just updates to reflect revised goals and objectivies. Just wanted to offer that. Bulk of changes are in Att A (preprint Q8). Want me to try to screen share?

Laura – sure, if you are able to screen share.

Andy – did submit a revised Att A in Sept, just want to note that those edits are no longer red lined. Just to be clear. What is red is only what has been modified since Sept. Changes focus on Comp 3 and 4. Biggest change was to Comp 4 – making MDS measures similar to how we evaluate them for Comp 3.

For Comp 3, interpreted our discussions for establishing floor for guarding against too much of decline, the floor was another solution as to what we were trying to solve with escalating benchmarks. So took away escalation and just doing floor. Also included chart for how we are implementing/interpreting our discussion for when facilities decline in performance. For those already above BM, if they have experience decline, that decline cannot exceed BM + absolute difference (2021 and 2022 benchmarks – change over time). Any questions so far?

Laura – makes sense to me. Any others have questions?

Andy – ok, in reviewing changes in national benchmarks. Relative change can be very different from absolute margin. Given new methodlogy that we're implementing, absolute difference provided a tiny bit wider gap for most measures. That is why you'll see that change from relative to absolute – believe it is a minor change.

Laura – if you don't mind, we did share this with our DQ collegues. Do you have an example or maybe follow-up via email so we ensure that we understand what the state is proposing.

Andy – sure, will dive into an example. First let me talk about Comp 4. Added new language for two MDS measures (influenza and pneumoccal), will be treating these measures the same as Comp 3.

So for example of absolute vs relative, showing you national benchmark for SFY 2020 and then for 2021, and 2022 – give you raw benchmark data. So we're clear, these are COVID years – can do what we are proposing but have concerns given COVID. Brings up questions about using relative methodology when comparator can change each year. Still evaluating/modelling this.

Laura – so if I'm tracking, want to use absolute (Column F) – maybe consider it a "gentler target", than relative. When looking at payment for SFY 2022, comparing Year 5 to Year 4. Is that correct?

Andy – yes. We are doing a lot of modeling, particularly on these facilities that are already high performers, when have small decline – trying to peg the numbers right.

Laura – so the state is trying to figure out how many facilities would be affected if using absolute vs relative difference.

Andy – yes and and also comparing this proposed methodlogy to what we originally proposed too.

Laura – so you are trying to understand what it would mean for your providers – just to make sure we have appreciation for both methodologies. We all want to pursue goal – rewaring providers for improvement/outcomes but also mindful that this is COVID time period.

Andy – appreciate you saying that. Difficult to establish methodology because raw data during this time is so challenged. Yes will look to provide you some modeling and how it will affect providers. Did meet with stakeholders, and there is consensus from stakeholders, even consumer advocates, to continue to make payments even if there are slight performance decrease.

Laura- if I recall, for Comp 3 and 4, there is a certain dollar amount allocated for each Comp. If don't meet one of the measures, then wouldn't get ¼ of the payment. And then that money gets spread to other providers, correct?

Andy/Victoria – yes, measures in Comp 3 are equal, so would not earn ¼ of payment – and then go into lasped fund pool and do redistribution or "bonus" payment at the end of the quarter.

Andy – also would note that we updated baselines b/c of updated data. Not a change to baseline methodology.

Laura - John, I think that covers the agenda for today.

John – thank you Andy for walking through. We are still on target to provide you feedback by COB Monday and already have discussion scheduled for Tuesday to walk through that feedback.

Gary – Brittani, did you have anything?

Brittani – we know there will be non-federal share questions, QIPP modeling, anything on CHIRP? And also plan to get you the evaluation plan today – so just a heads up.

Gary – on stuff that CMS is sending Monday, will Component 1 issues be included? And is OACT writing those, or FMG?

Laura – yes OACT will be on Tuesday's call and contributed to the question set.

Gary – thanks yes wanted to confirm that.

John – anything else?

Gary – not that I can think of.

John – thank you Texas team, we'll talk to you on Tuesday.

TX-CMS Call on 10/19/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
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Alex Loizias	Rebecca Burch Mack	Mara Siler-Price	Anna Bonelli
Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda**:**

-Review of CMS Round 4 Feedback

John – I know we sent you feedback yesterday. Tried to make it easy as possible by highlighting comments in new color – bright pink this time. Any specific questions? Any areas where you need clarification? Or you just want to dive into issue we talked about couple days ago re how Component 1 is incorpated in rates?

Gary – we'd like to focus on comp 1 and after we've had more time to review CMS comments, discuss those on Thursday

John – great, we had included this in some of the written feedback on Comp 1. We want to understand how Comp 1 is incporated into rates. The state has been adament that it's an adjustment to base rates and there's an opportunity for reconciliation. If it is reconciled then there's a possibility to revise rates. This is an opporunity for our actuaries and yours to talk and see if we have any questions.

Gary – that sounds right

John – Rachel or EvanD, might be helpful for you to explain your perspective on Component 1 in QIPP. And then we can ask to see if OACT has any follow up qs.

Rachel – sounds good, kick over to Evan.

Evan – when we talk about comp 1 for QIPP, it's similar to other DPPs and we think about it in similar fashion. High level, there's a an est amount of money. Then the question becomes how is that funding then spread across rates for MCOs to pay out. It's based upon utilization and we're looking at historical utilization for how to spread Component 1 money.

When we're setting future rates there's always the possibility that we can't predict future expenditures. Past 18 months is good example. Greatest risk is that caseload is going to vary from what was initially estimated. The PMPM rate paid to MCOs is based on number of members and then the actual utilization spread across MCOs, risk groups, SDAs etc. I missed the last call so not sure how far we got with discussion of reconciliation but that's what we've attempted to do with this rate add on. We used best available info over the summer time – 6 months before period even begins. We estimate caseload, caseload distribution, utilization of services and providers. We've used that info to calculate what those rates will be as well as risk margins etc so that we're reimbursing MCOs appropriately. That's what we look at to determine if these are rate add ons.

John – Thank you. Is it accurate to say for Comp 1 that there is a known target (known amount of dollars) that will incorproated into that component? Do you know the amount up front or is that subject to change?

Victoria – it's an estimate, we have a known percentage of program funding we want to dedicate to Comp 1 but as program fluctuates based on caseload etc then that proportion of funds would increase prorportionately. Gross dollar amount scales as caseload scales.

Evan - At the beginning when we're calculating the amount, we set a target but it's based on a point in time estimate. We've estimated based on best available data but there are unknowns with FY22 and caseload variation. Prior to 18 months ago when we were looking at UHRIP and QIPP, the actual values were aligned with the estimated values but the events over past 18 months have been hard to predict and let to more variability.

John – very hepful. Does OACT have any follow up qs?

Layla – thanks, John. Quick follow up question – for QIPP, the proportion we're discussing is 110%?

Victoria – correct, 110% of the percentage of the state share of the FMAP. Ends up being in the neighborhood of 40%

Layla – at the time when the reconciliation is performed, how do you determine the percentage of Comp 1?

Vicotira – based on number of the QIPP dollars that have been paid out already

Layla – that's all I have for now.

John – what would be helpful is if you could include some of this explanation in the written feedback back to CMS.

Gary – we will definitely do that. Since we have some time, Trey may have couple qs about Rd4 comments.

Trey – first, the Sept 7 letter, do you have any update on that letter? ETA on when we can expect response?

John – my understanding is that Dan and Stephanie have had conversations. As you can imagine that letter and decisions are with CMS leadership. Don't have any updates at staff level.

Trey – We want to follow up on hold harmless. CMS is reiterating request for attestations and documentation. We've provided language on certfications and attestations – are you saying what we've provided is not sufficient?

Rory – We haven't made formal determination. We remain concerned that attestation is not aligned with what we requested and we mentioned that in recent comment round. Before we make determination want to make sure we have full documentation. We understand your position and why the attestation you provided is what it is. I'm concerned about whether it gets us to where we need to be with 1903w compliance. State has said they don't feel comfortable going to providers and requesting info so we're just trying to make sure we understand the full picture.

Trey – we can follow up on that response. Do you guys have examples of what other states are using for this attestation?

Rory – we don't have this exact circumstance in other states. When we we've become aware of similar circumstances,we've requested similar attestations. But again it's not this exact circumstance. When we identify concerns with payment redirection, we have requested similar attestations but it depends on the situation.

Trey - can you send us those examples?

Rory – we can send what we have.

Trey – is TX the first state to encounter this?

Rory – no, it is not.

Trey – then can we get copy of other state's attestations?

Rory – we can look to see what we have available.

Bluna- what state has closest arrangement to ours?

Rory – I don't want to get into calling out specific states. There have been multiple other states with something similar and we've requested addtl info or similar atteststions. Would have to check with my team to clarify which states and what info.

Bluna – any states that have given you info that is satisfactory to you?

Rory – limited number of these arrangmenets and we're in active discussions with other states on similar issues.

Bluna – so there's no attestation from another state we could use because those states haven't provided it yet?

Rory – that's safe to say

Victoria – so you've requested these attestations from other states but none of them have provided any attestations?

Rory – correct.

Victoira – is there a reason that the attestation isn't being asked of all states with provider taxes?

Rory – we've asked it of states in other similar situations. Going back to 2019 when we first talked to TX about LPPF arrangements, we asked pointedly if the state was aware of payment pooling and redirection and the state said no originally so we didn't ask other questions. Then we became aware through our own research of potential pooling and redirection arangements so that's why we began asking for attestations. That's similar to the cirumstances we've encountered in another state.

Victoria – some of the discussions between FMG and the state at that time was because the state became aware of things we weren't aware of previously. The state has never obfuscated info from CMS; we became aware of things as time went on. One of our questions when you describe a similar situation in another state, I just wanted to understand what that means. Because having a provider tax, statewide or jurisdictional, is the similar situation. So can you be more specific about the similar situation?

Rory – it gets to the idea of similar arrangements on the backend for pooling and redistributing Medicaid payment. What you seem to be getting at it is if we're being consistent across states and the answer is yes.

Victoria – for other states that you've requested, are there SDPs that are pending and not approved?

Rory – I'd have to look at specifics and get back to you.

Trey – yes would be helpful. We're just looking for how we can resolve issue and move forward. If the attestation language we're currently using isn't working then is there language out there we can use and mirror? If you already have something that's acceptable then we'd be happy to use.

Rory – we did provide language in prior question set that was pretty specific about what were looking for. We can look back at it and see if there's similar language that other states have provided. We're open to saying that if something is more palatable to the state in terms of language that provides similar level of assurance then we're willing to work with you. Language needs to ensure that there aren't pooling arrangments in place that redistribute Medicaid payments that are tied to a provider tax. We have concerns that if there are localities or local providers involved then we need to ensure that the attestation is at that level too. Needs to get to the provider level.

Victoria – when you send follow up, can you provide the citation that governs Medicaid providers and assignment of payment to others or use of funds once duly received? Looking for citation that restricts use of funds – specific question on Medicaid providers and assignment of payment.

Rory – I can look back but 1903w and implementing regulations is our key concern.

John - last couple of minutes, we have Thurs call scheduled. Please send us agenda items but we are happy to discuss comments sent to state on Monday.

Gary – let's plan to do that on Thursday

John – put in plug for Monday call, know you just submitted evaluation documents. I think our quality team would like to speak to your quality team regarding those docs. Are you agreeable?

Gary – I think that works but will let you know if we need more time.

Andy Vasquez – yes that would work.

October 19, 2021

RE: Hold Harmless

Texas: State has provided information for the attestation as requested by CMS – are we saying this isn't sufficient?

> CMS: We haven't made a final determination; we want to make sure we have all of the information available to be able to make a final decision regarding if the financing is permissible.

Texas: Can you share attestations that other states have provided to CMS that were acceptable?

Texas: If no other states have provided attestations, why is Texas being asked to do so?

Texas: Why aren't all states that have provider taxes being asked to provide attestations?

CMS: When we have become aware of similar situations, we have asked them to provide attestations.

Texas: Has CMS approved state directed payment proposals in other states even if they didn't provide an attestation?

> CMS: We will need to get back to Texas

Texas asked for the specific statutory citations regarding restrictions on Medicaid providers using payments after they've been received.

TX-CMS Call on 10/21/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
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CMS Attendance

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Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

- **Review of CMS Round 4 Feedback**

Gary – we want to use this call to discuss comments or questions with the CMS Round 4 responses and we have a full complement of staff. Victoria has a question for Rory, if he's on.

John – Rory is not able to join us for today's meeting.

Gary – Do you want to put question to John and he can relay to Rory?

Victoria – We had talked with Rory about a number of items that he was going to follow up on and we wanted to check in on an ETA for that follow up.

John – We're happy to connect with Rory and see what the ETA is.

Victoria - Thanks

TX-CMS Call on 10/21/21 Notes

Gary – want to open it up to Texas staff to see if there are any questions or comments on to CMS' Round 4 questions…….I'm not hearing anything. I think, for Monday's call, we talked about talking through the evaluation. Is that your recollection, John?

John – Yes and we've already cleared with our quality folks. They've confirmed for Monday.

Gary – We haven't thought through the Wednesday meeting agenda yet but will work on it.

John – Great and we will connect with Rory and see when is a good time to have that follow up.

Gary – Sounds good…and of course, we're open to any agenda items you guys would like to discuss.

John – Sure, we'll poll the team and see if there's anything. That sounds like a good plan for Monday and of course we'll follow up with Rory.

Brittani– We are working on next batch of responses. And our hope is to get it to you by tomorrow…

John – That sounds great. That may obviously allow us to talk through any of that next week.

Gary – Thanks, Brittani. I guess we'll talk to you all on Monday.

John – Thanks, goodbye.

TX-CMS Call on 10/25/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	S Dow	Evan Dial
Rachel Butler	Michael Ghasemi	Denbigh Shelton
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CMS Attendance

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Agenda:

- **Review Revised Evaluation Plan for New SDPs**

John – Welcome, I know the agenda today was to walk through the revised evaluation plan that TX provided.

Gary – Correct, but before we go there Stephanie had a question and comment.

Stephanie – Hi everyone, happy Monday. We just wanted to mention a critical timeline for the state. In our Sept 7 letter we had an option to make UHRIP payments in 2022 and those payments are not currently being made because we don't have CMS approval. So at this point for us to begin making UHRIP payments effective December, we would need approval by November 1st. I mentioned this to Dan last week but also wanted everyone on this met9jg to have that info. We would need approval November 1st to begin making payments in December otherwise UHRIP payments will be delayed.

John – So payment is needed in November to begin making December payments?

Stephanie – yes, to be able to make payments to the MCOS. And then there would be a process for making retroactive payments. But for us to make payments to MCOs in December, we'd need approval by November 1st.

John – and then goal is for MCOs to make provider payments in January 2022?

Steph – We'd want them to make payments as soon as possible but obviously need to follow pament processes.

John – Thanks, Stephanie. We will provide this information to leadership and will do that today.

Steph – Thanks

Gary – Next, let's move on to the evaluation.

Emily – if CMS would like us to walk through evaluation, we're happy to do so.

Jen Maslowki – that'd be helpful, if you could just highlight changes. We can wait til you're done or ask questions as we go.

Emily – Sure, stop me as you have questions…

We made a number of changes based on direction and feedback from CMS. Biggest piece is that we combined the four separate evalation plans from four separate DPPs into one evaluation plan. In order to assure attribution to DPPs, we'll use provider reported metrics only. Table 15 in updated evaluation plan lists the measures that will be used…hopefully you've seen that . Some measures are used across different programs but what they'll be giving us is specific to each DPP.

Per CMS guidance we've added outcome measures to RAPPS and CHIRP. Providers will also report on process measures…all evaluation measures including statewide measures are in Appendix 1.

In the first year of the program per CMCS guidance, we'll request that providers submit measures stratified by managed care beneficiaries only as their systems allow in the first year. CY 21 will be the baseline however, it's not known yet what impact COVID 19 will have and how the newly stratified data will impact reporting…we'll also incude statewide measures provided by EQRO and not attributable by one program or another but will be limite to managed care data. I'm happy to answer any questions.

Jen – that's great. You talked about outcome measures, one thing we'd talked about previously was qualitative data such as provider interviews. In one set of responses, you said it's already being included in "structure questions." Can you talk more about that?

Emily – we're having UHRIP hospitals report on status of HIEs so we worked with HIE subject matter experts to help us design some follow up questions…just one example. We have templates for structure measure reporting, mostly yes or no but have some follow up questions depending on answer. In future years using both structure measures and process measures, we could look and see which of those structures are having a better impact on outcomes…compare that qualitative data across providers. With programs this size, we don't want to have a free for all so we have reporting templates with open fields.

Jen – was the template included in the evaluation plan?

Emily – it is not. Our change in evaluation is intended to move to all provider reported measured in order to attribute outcomes and quantitative data to DPPs…with this amount of data and DSRIP we've discussed the importance of quantitative data. Our plan is not focused on structure measures but rather the outcome measures.

Jen – great…we're still reviewing the evaluation plan. We'll continue to go through it again and I'm sure will have follow up questions. I'm joined by Allison and Liz from DQ, did you have any follow up questions?

Allison – No, none from me.

Liz – One quick question. We talked about needing a year for state to get EHR reporting in place for these measures. Is this an expectation for next year's evaluation?

Emily- are you speaking to Medicaid managed care reporting requirements?

Liz – yes

Emily – as we have indicated, we received feedback from providers when we first proposed these measures and providers told us they'd have trouble stratifying by Medicaid managed care so in the first year we wanted to give providers some lead time to be able to do that in the 2nd year. We don't think it'll be a huge difference in data because 95% of our program is in managed care.

Liz – Thanks, I just wanted to confirm.

Jen – Following up to Liz's question – will you submit any stratified data (with providers that are able) this year or are you waiting on 2nd year when all providers have made system changes?

Emily – P lan is to collect CY 21 data for baseline. Our goal is to set performance targets base on CY 21 data. We talked about having an update to evauationl plan as needed once we get final CY 21 data…we usually don't have complete data when we submit our preprints in January…so we'll need to see what the providers are able to provide and determine reasonable goal setting.

Jen – Thanks, Emily…I think that's all we have for today.

John – Well, I think that does it for today's evaluation plan agenda. Does the state have anything else?

Gary – We wanted to follow up about Rory and the info he's going to give us. He's not on the call today.

John – I will check in with him. I sent him a note and I know he's having to run some info by their OGC. They were hoping to have some info for the state by the end of this week or the beginning of following week.

Gary – Thank you. For Wednesday agenda we'll get back to you with some items but if you have anything you'd like to discuss, we're happy to add.

John - great, we'll let you know if we have any agenda items….Thanks and good bye.

TX-CMS Call on 10/27/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
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Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

- CMS response to HHSC's CHIRP proposal: 90% of ACR
- Update (if available) on status of September 7 letter
- Other items CMS wishes to discuss

- Alissa - 90% of ACR is still under going active discussion with policy officials and same with second agenda item on the Septembert 7 letter.

- Gary – Victoria or any other Texas staff, any follow-up?

- Victoria – appreciate the update.

- John - wanted to let state know haven't forgotten about information you requested from FMG. On previous call, had alluded to FMG getting feedback to you by end of next week and will do coordination to be sure that that is on FMG's radar. Laura, anything else we're tracking?

TX-CMS Call on 10/27/21 Notes

- Laura – still reviewing responses submitted by the state from late as week. FRT is acvitely reviewing. Just wanted to let you know that is ongoing too.

- John – anything else from Texas team?

- Gary – HHSC staff anything? May have set record for shortest call. We will send you agenda items for the Friday call.

TX-CMS Call on 10/29/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
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Alex Loizias	Rebecca Burch Mack	Mara Siler-Price	Anna Bonelli
Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

- Any updates on response to Sept 7 letter
- UHRIP approval status
- Confirmation that no further preprint modifications are needed
- Any CMS topics

Gary – have seen these agenda items before, a new one is the 3rd bullet about any further modifications to preprint needed. Our understanding is that no further modifications are needed but wanted to confirm with CMS.

Alissa- I have no further updates on response to Sept 7 letter. Discusisons with policy officials continue. Those policy discussions would inform UHRIP approval so don't have any further update that. But in terms of preprint updates, will turn to Laura.

Laura – we are reviewing the revised preprint for QIPP and other preprints as well. Last Friday, received Round 4 responses. We are reviewing all those documents. Don't think we can confirm at this point that no further modifications are needed but they are under active review.

Andy – process question. AsCMS team is going through, if there are questions, will you bring them up as you encounter them and not saving them all at once?

Alissa – yes, that is correct. So we can certainly talk about any questions next week.

Gary – okay, nothing further for Texas team for today.

Alissa – okay, we will talk again next Tuesday and will get an appt out to you no later than Monday.

TX-CMS Call on 11/2/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
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Kathi Montalbano	Dara Nix	Kate Hendrix
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CMS Attendance

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Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

- Update from FMG
- CHIRP
- Any CMS items

Alissa – hope everyone is well. Start with status of CHIRP. We do have update for you – related to the proposed sizing of CHIRP, payments under which the state has agreed to limit to no more than 90% of ACR, we have no additional concerns or questions about the size of the program. However, we remain concerned about the underlying financing of the CHIRP payments.

So again, to repeat, related to the proposed sizing of CHIRP, payments under which the state has agreed to limit to no more than 90% of ACR, we have no additional concerns or questions about the size of the program. However, we remain concerned about the underlying financing of the CHIRP payments.

Gary – thank you. Let me see if Victoria or others have any follow-up.

Victoria – if you could please provide that to us in writing, we would appreciate it.

Alissa – yes, we will include it in forthcoming feedback back to the state.

Gary – okay, ready to turn to the financing item.

Rory – as we have previously stated, we still have outstanding questions and information that we need related to LPPF. To retietrate what is outstanding, we have asked previously asked for information on what is going on what these arrangmeents, including copies of such arrangements. Have not received that to-date. As an alternative, we have indicated that the state could provide an assurance from the participating providers or from the state (attesting on behalf of the provider) that no redistrubition or pooling is occurring. We are looking to get a level of assurance from the provider (or the state on behalf of provider). If state is able to provide an assurance, we would want to understand what the state has done to be able to provide this level of assurance.

That is what is outstanding from our perspective. Also, I know the state recently requested information from CMS and we are still developing those responses. In your questions to us, you had asked about where we have acted in other siutations that may be similar to Texas – we are planning to provide information related to 2 states where we have had issues related to pooling or redistrubtion. The first, Louisiana, we had asked them to provide an assurance. We have continued to work with them and that attestation language but state withdrew the original preprint and we are now working with that state on a revised proposal. Second state is Missouri. We did have an agreement from state to end the pooling arrangement and state has since submitted preprints and CMS is actively reviewing. We will provide more information in writing but just wanted to share a preview.

Also asked about statutory basis (your question 4) for restricting providers from utilizing Medicaid payments that they have duly earned after it has been received by the provider. We have been working to gather information from the state to verify compliance with 1903(w). We plan to respond in writing and clearly lay out in writing our position of 1903(w) hold harmless issues.

So, that is all a preview of what is to come in writing.

Alissa – just want to remind TX of STC 33, and so our next round of feedback will be sent to Texas on November 10.

Victoria – you mentioned a written agreement with Missouri, would you be able to provide that to us?

Rory – can take the question back. Know we plan to provide you information in writing on MO. Anything else?

Gary – was going to ask when CMS was going to send feedback to state, but Alissa already covered that.

Alissa – Also, just want to note that in the Novemebr 10 passback, there will be some quality questions. John may have more to say on that?

John – there will be a question about QIPP evaluation plan – our quality team had couple of smaller issues to raise.

Alissa – think that is it from our side.

Gary – ok, speak to you on Thursday.

TX-CMS Call on 11/4/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
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Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:
- preview of quality questions

Gary – thanks for sending those 2 items before today's call. Helpful to understand CMS' questions before receiving the pass back next week.

Laura – thanks and yes, we have invited our collegues from DQ – Jen Maslowski and Liz Clark. Hopefully you can hear the things we're interested in and that you'll see in the next pass back.

Jennifer – regarding MDS data in QIPP evaluation plan. Know we talked about this previously. Talked about state needing raw assessment data to limit to medicaid managed care population. State had said that this was something that could be done in 2023 and when reviewing the evaluation plan, I did not see this detail discussed so wanted to take this opportunity to ask about it.

Andy – sure, let me start and Erin Cibrone and Calvin Johns are on who can discuss further. You are correct that we cannot do this for SFY 2022 but plan to do for SFY 2023. In prep for SFY 2023, state is currently analyzing system changes that would be needed and would like to setup a technical TA call in the future to make sure we have the calculations right. When we attempted to do this few years ago,

had encountered some calculation issues. B/c the eval plan is for SFY 2022, didn't include this level of detail since this QIPP preprint is not a multi-year proposal.

Jennifer – yes, that all sounds good Andy. That was my only question on that – do think it would be helpful to include some language in SFY 2022 plan just so we know what is the plan for SFY 2023.

Andy – we could add some specificity in the table re: population, perhaps a footnote that this will be limited to Medicaid managed care for SFY 2023.

Jennfier – makes sense. More just for clarification, can you remind us what portion of nursing facility population is mediciad vs private?

Andy – want to clarify your question. Within Medicaid nursing homes – are you asking what percent is Medicaid vs other?

Jennifer – exactly.

Andy – Victoria, can you say?

Victoria – for nursing facilities in QIPP that are privately owned, there is a minimum Medicaid utilization of 65%. For publicly owned facilities, don't have that same threshold but will see that many have a high percentage of Medicaid beneficiaries. In general, 60-70% of nursing facility residents are on Medicaid.

Jennifer -thank you, that's helpful. Wanted this clarification before we provide you further written comments.

Liz – that's a great solution Andy for documenting the MDS data plans for SFY 2023 in the preprint.

Andy – if you don't mind me asking, do you anticpate any QIPP or QIPP evaluation questions next week?

Jennifer – no you covered our questions.

Alissa – anything else from the state?

Gary – Don't think so.

Laura – anything you would put forward for next call?

Gary – we will get back to you.

TX-CMS Call on 11/8/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
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Joelle Jung	Emily Zalkovsky	N Boston
Linda Hunyh	Shannon Brown	April Ferrino
A Campbell	Emeka Anyanwu	Frances Morgan
Erin Cibrone	Noelle Gaughen	

CMS Attendance

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Ann Marie Costello	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
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Agenda:

- Outstanding (open) item -- Non-federal share (attestation)
- Call schedule for Thanksgiving week (CMS availability)

Alissa – we have everyone we need, ready when you are.

Gary – we sent a couple of agenda items over earlier today. First item is about outstanding items and what we believe are the substantive outstanding items. Victoria, any specific questions for CMS about first agenda item?

Victoria – no specific questions, just want to confirm that written feedback that will be sent on Wednesday will include non-federal share items? Believe those are the outstanding issues.

Rory – that is correct. Two issues we have concerns about -- hold harmless arrangements that violate 1903(w) given agreements that we think are in place. That's the first issue and second issue is the two localities in which taxing hospitals are receiving total Medicaid cost back. Those are the issues that we

are asking about and we are trying to be as descriptive as possible in our pass back. We will also include information about other states with similar financing issues.

Victoria – so there are two remaining substantive issues, I also understand that there are other minor issues as well?

Alissa – largely correct. Doing our due diligence as is relates to QIPP and BHS. But these 2 issues that Rory discussed are the substantive remaining issues for the other preprints.

Victoria- that makes sense, thanks.

Gary – is our Wednesday call scheduled yet?

Alissa – No, looking at 4pm on Wed if that works for Texas, but not scheduled yet. My assistant is returning tomorrow.

Gary – will we get the written feedback before that call on Wednesday?

Alissa – let me talk to John and Laura to see if that's possible.

Gary – the other agenda item we have is about Thanksgiving week. Wanted to check with you on your availability. Texas is available 24/7 but wanted to be sensitive to your schedule.

Alissa – I will be available. Couple things to note – this Thursday is a federal holiday – so next week we will meet on Monday, Wednesday, Friday and then Tuesday and Friday of Thanksgiving week. Some of us will be here that Friday after Thanksgiving.

Gary – thanks for that.

Alissa – We will do our best to get our feedback to the state before this Wednesday's call.

Gary – so we will have a call on Wednesday and then our next call will be on Monday. I think that all we have for today. Speak with you all on Wedneday.

TX-CMS Call on 11/10/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	Bluna
Andy Vasquez	S Dow	Evan Dial
Rachel Butler	Michael Ghasemi	Denbigh Shelton
Trey Wood	Stephanie Tourk	Courtney Caruthers
Joelle Jung	Emily Zalkovsky	N Boston
Linda Hunyh	Shannon Brown	April Ferrino
A Campbell	Emeka Anyanwu	Frances Morgan
Erin Cibrone	Noelle Gaughen	Brooke Ellison

CMS Attendance

Daniel Tsai	Layla Fraser	Jennifer Clark	Tom Caughey
Ann Marie Costello	Tristan Cope	Rory Howe	Monica Neiman
Alissa Deboy	Beverly Lofton	Stuart Goldstein	Mehreen Rashid
John Giles	Allison Weaver	Charlie Arnold	Carrie Smith
Laura Snyder	Elizabeth Clark	Jonathan Endelman	Norina McAuliffe
Juliet Kuhn	Christopher Thompson	Andrew Badaracco	Michelle Beasley
Eli Greenfield	Jeremy Silanskis	Richard Cuno	Daria Romanov
Diona Kristian	Jocelyn Velez	Deborah McClure	James Burns
Shamberkia Wise	Tamara Sampson	Jennifer Maslowski	Amber MacCarroll
Alex Loizias	Rebecca Burch Mack	Mara Siler-Price	Anna Bonelli
Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

Alissa – did not have formal agenda for today, but can provide an update on where we are and also talk through the written feedback that John just sent to the state prior to this call. So, as for an update from CMS – thank you very much for all of the back and forth on QIPP and BHS. We anticipate very shortly approving both QIPP and BHS. So in the next few days you should be seeing approval letters for those.

Gary – yay, thank you.

Alissa – we appreciate all the work in getting those complete.

Gary – thank you very much. That's great news.

John – so it is hard to compete after that - Alissa gets to give you the good news. So just sent before this meeting, I sent you our latest pass-back. Our latest feedback is highlighted in blue. CMS' first response is on page 16 and related to size of CHIRP. Already gave you this information verbally but wanted to

provide in writing per Victoria's request. Shouldn't look different from what we told you verbally but will pause and see if there are any questions from state.

Gary – I don't, haven't had a chance yet to review passback.

John – yes apologize for that. Just confirming in writing. Next update is on page 19. Related to question about what happens if 1 of 17 hospitals does not give you ACR data. So we are providing that information to you – in that should a hospital fail to provide that data, the adjustment should go back to the start of CHIRP which would be the start of the rating period.

Gary – HHSC, any questions? Guess not.

John – next update is on financing section. Starts where Texas had number of questions back to CMS – page 80 of the document. Rory, do you want to say anything about these updates?

Rory – Hi Gary. I gave a preview during our last call of what to expect and happy to provide a quick overview now. So first question on bottom of pg 79, as indicated before, we are providing information on attestations that we have requested in other states – do talk about LA and MO. Detailed information there. On the 2nd question, it is in response to whether we ask all states with provider taxes to do attestations. We explained that we do not and explained the reasoning. We also consolidated our prior request for information from the state to show that the LPPFs meet statutory requirements. Third response provides attestation that we were actively working on with LA but did not finalize because state withdrew those prepents. And the LA situation is not exactly the same as TX but wanted to provide as an example. For LA, provider related donation were the concern – despite similarities, don't know if language is aligned for Texas' purpose. For the 4th question, the state asks about statutory basis for restricting providers from utilizing Medicaid payments that they have duly earned after it has been received by the provider, know we have talked through this and indicated that our issue is with the hold harmless issue and that we are not creating a new requirement on how Medicaid providers use their payments. Question 5 is covered in response to the question 1. That covers it for financing responses. There is a fair amount of information and understand that you haven't had a chance to review, but wanted to give you a preview.

Gary – thanks Rory. What pages do your responses start on?

Rory – top of page 80.

John – Gary, there is also a response on pg 84 related to status update on Sept 7th letter. So we provided a response there. So that reflects changes to the document. Can give you page numbers again – pg 16, 19, and then Rory starts on top of pg 80. Those are the highlights in blue.

Laura – nothing from Laura?

Laura – nothing further from me Gary.

Gary – thank you and appreciate the news about about QIPP and BHS. Will work to provide timely feedback.

Alissa – just a heads up that some of us will be at NAMD for our Monday call.

Gary – yes, I think Stephanie will be at NAMD too. Thank you guys again.

TX-CMS Call on 11/15/21 Notes

Texas Attendance

Stephanie Stephens	Emily Sentilles	Megan Wolfe
Christine Meier	Maggie Griffith	Calvin Johns
Gary Young	Sheila Dhir Hughes	Victoria Grady
Kathi Montalbano	Dara Nix	Kate Hendrix
Brittani Bilse	Sarah Diseker	D Dillon
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Shamberkia Wise	Tamara Sampson	Jennifer Maslowski	Amber MacCarroll
Alex Loizias	Rebecca Burch Mack	Mara Siler-Price	Anna Bonelli
Courtney Miller	Alexis Gibson	Paul Spitalnic	Fran McCullough

Agenda:

Gary – good to go when you guys are Alissa.

Alissa – is there anything in particular you want to talk about today Gary?

Gary – not ready to discuss the November 10th pass back yet. Maybe for this Wednesday. Is there an ETA for QIPP and BHS approvals?

Alissa – expect to deliver those to you sometime today.

Gary – Fantastic.

Alissa – this may be a short call. If you did have questions, wanted to be sure Rory was here for anything financing related.

Gary – let me check with Victoria since most of the items fall within her wheelhouse.

Victoria – don't have any questions at this point on the pass back. Quick question on approval letters. I missed last Wednesday's call. For the approval letters, will they be retroactive September 1?

John – Yes, will be retroactive to the start of the SFY 2022 rating period.

Victoria – are there any contingencies in the approval letter?

John - Documenting a lot of the changes that we made together. Laura, correct me, there may be a quality contignency.

Laura – the quality aspects is referencing future work.

Vicrotia – that is helpful, thank you. Trying to get ready for stakeholder communications.

Gary – is the future work in respect to just QIPP or BHS too?

Laura – believe it is just QIPP, on evaluation pieces. But again for future, not for this SFY 2022 rating period.

John – really just documenting the good progress we have made over the last several months.

Gary – anyone else have any questions or comments from HHSC? Guess we are good.

Alissa- I won't be here on Wednesday but John and Laura will. Sounds like we have an agenda for Wednesday – to talk through last week's pass back from CMS.

Gary – we may want Rory available for that call.

Alissa- got it. Thank you, have a good evening.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD# 21-001
RE: Additional Guidance on State Directed Payments in Medicaid Managed Care

January 8, 2021

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 C.F.R. Part 438 govern how states may direct plan expenditures in connection with implementing delivery system and provider payment initiatives under Medicaid managed care contracts, including those with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs), herein referred to as managed care plans. These types of payment arrangements permit states to direct specific payments made by managed care plans to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs.

In November 2017, CMS published guidance, a related appendix with examples, and a preprint for states to obtain approval of state directed payments under 42 C.F.R. § 438.6(c). In May 2020, CMS also published guidance on managed care flexibilities to respond to the COVID-19 public health emergency. Overall, CMS has reviewed and approved more than 450 state directed payment arrangements since this part of the regulation took effect beginning with contract rating periods on or after July 1, 2017. Based on our reviews, CMS believes additional guidance is needed to:

- Clarify existing policy and alleviate burden faced by states by proactively addressing common questions that arise during the preprint review;
- Enhance program integrity in the use of state directed payments; and
- Remind states of the quality-related requirements that must be met to secure CMS approval.

To this end, this State Medicaid Director Letter (SMDL) provides guidance on the broader policy regarding state directed payments, clarifies what is considered a state directed payment, and provides additional clarification on the federal requirements for state directed payments.[1]

[1] The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Contract Requirements Considered to be State Directed Payments

In general, states are not permitted to direct the expenditures of a Medicaid managed care plan under the contract between the state and the plan or to make payments to providers for services covered under the contract between the state and the plan (42 C.F.R. §§ 438.6 and 438.60). Under the 2016 Medicaid and CHIP Managed Care Final Rule[2], CMS permits only the following exceptions that allow states to make payments directly to providers or direct managed care plan expenditures for plan-covered services:

- State directed payments that comply with the requirements at 42 C.F.R. § 438.6(c);
- Payments by the state to providers required by a specific provision of Title XIX or in another regulation implementing a Title XIX provision; and
- Permissible pass-through payments that comply with the requirements of 42 C.F.R. § 438.6(d).

For state directed payments, 42 C.F.R. § 438.6(c) specifies the ways states may set parameters on how expenditures under managed care contracts are made by managed care plans to assist states in achieving their overall objectives for delivery system and payment reform and performance improvement. These permissible state directed payments may include: value-based purchasing models, multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives, or fee schedule requirements for provider reimbursement (e.g., minimum fee schedules, maximum fee schedules, and uniform increases). These categories are not mutually exclusive.

In the November 2017 CMCS Informational Bulletin (CIB), we noted instances when states may include general contract requirements for provider payments that would not be subject to approval under 42 C.F.R. § 438.6(c). CMS also noted these contract requirements would not be state directed payments under our interpretation of the regulation as long as the state is not mandating a specific payment methodology or amounts under the contract. In addition, CMS noted that when the provider payment is tied to the utilization and delivery of a specific service or benefit provided to a specific enrollee under the contract, such payments are not pass-through payments as defined in 42 C.F.R. § 438.6(a) and not subject to the requirements under 42 C.F.R. § 438.6(d). In particular, the November 2017 CIB described two scenarios:

> First scenario: States contractually implementing a general requirement for managed care plans to utilize value-based purchasing or alternative payment arrangements when the state does not mandate a specific payment methodology and managed care plans retain the discretion to negotiate with network providers the specific terms for the amount, timing, and mechanism of such value-based purchasing or alternative payment arrangements. An example of this would be when a state implements a general contract requirement for managed care plans to make 20 percent of their provider payments as value-based purchasing payments.

[2] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 Fed. Reg. 27498 (May 6, 2016) (available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered).

> Second scenario: States contractually implementing a general requirement for the managed care plans to increase provider reimbursement for covered services provided to Medicaid beneficiaries covered under the contract, as long as the state is not mandating a specific payment methodology or amounts and managed care plans retain discretion for the amount, timing, and mechanism for making such provider payments. An example of this would be when a state implements a general requirement for managed care plans to increase their overall rates for primary care services provided to all Medicaid enrollees covered under the contract.

When CMS published that guidance, we believed that both types of general contract requirements for provider payments left sufficient discretion to plans and maintained the link between payments and delivery of services under the contract. We believed that these types of contract requirements would not trigger the prohibition and limits in 42 C.F.R. § 438.6(c) and that the general contract requirements maintained the link between payment and delivery of services under the contract as to not trigger the prohibition and limits in 42 C.F.R. § 438.6(d) on pass-through payments. As CMS has continued to review managed care contracts and rate certifications since the publication of the November 2017 CIB, general contract requirements described in the first scenario seem to continue to leave sufficient discretion to plans by including minimal direction from the state and link payments to the delivery of services under the contract such that prohibitions and limits under 42 C.F.R. §§ 438.6(c) and 438.6(d) are not triggered.

However, CMS has grown concerned that the November 2017 sub-regulatory guidance created an unintentional loophole in regulatory oversight in relation to general contract requirements described in the second scenario that require managed care plans to increase provider reimbursement for covered services. For example, some states are including general contract requirements for provider payments that require an additional amount be added to the contracted payment rates for a specific service (e.g., hospital services) but without any further accountability to ensure that the additional funding included in the rate certification is linked to a *specific service or benefit provided to a specific enrollee* covered under the contract (see the definition of pass-through payment in 42 C.F.R. § 438.6(a)).

CMS is concerned that vague contract requirements, particularly when significant amounts of funding are being added to the rates and rate certification(s) as part of the actuarially sound capitation rate, do not provide sufficient accountability to ensure that the additional funding will be used to pay for specific services provided to specific enrollees covered under the contract. Additionally, such vague contract requirements do not provide sufficient accountability for the substantial increase in funding and circumvent the intent of the 2016 Medicaid and CHIP Managed Care Final Rule and the subsequent 2017 Pass-Through Payment Final Rule[3] to improve the fiscal integrity of the program and ensure the actuarial soundness of all capitation rates. As stated in the preamble of the 2016 Medicaid and CHIP Managed Care Final Rule, "[w]e believe that the statutory requirement that capitation payments to managed care plans be

[3] Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems; Final Rule; 82 Fed. Reg. 5415 (January 18, 2017) (available at: https://www.federalregister.gov/documents/2017/01/18/2017-00916/medicaid-program-the-use-of-new-or-increased-pass-through-payments-in-medicaid-managed-care-delivery).

actuarially sound requires that payments under the managed care contract align with the provision of services to beneficiaries covered under the contract. … In our review of managed care capitation rates, we have found pass-through payments being directed to specific providers that are generally not directly linked to delivered services or the outcomes of those services. These pass-through payments are not consistent with actuarially sound rates and do not tie provider payments with the provision of services." We further explained that "[a]s a whole, § 438.6(c) maintains the MCO's, PIHP's, or PAHP's ability to fully utilize the payment under that contract for the delivery and quality of services by limiting states' ability to require payments that are not directly associated with services delivered to enrollees covered under the contract."[4]

In light of these concerns, CMS has reconsidered the previously published guidance to realign our implementation of the regulation with the original intention of the 2016 Medicaid and CHIP Managed Care Final Rule and the 2017 Pass-Through Payment Final Rule. If the state includes a general contract requirement for provider payment that provides for or adds an amount to the contracted payment rates but the provider payments are not clearly and directly tied specifically to the utilization and delivery of a specific service or benefit provided to a specific enrollee under the contract, such contract requirements must be modified to comply with either 42 C.F.R. § 438.6(c) or (d). Absent modification of such contract requirements to comply with 42 C.F.R. § 438.6(c) or (d), we would consider such contract requirements out of compliance with federal regulations. This interpretation is consistent with the intent of the 2016 Medicaid and CHIP Managed Care Final Rule and will ensure federal regulatory oversight of managed care payments. Therefore, when a state includes a contract or payment requirement, even if vague or that leaves some discretion to the managed care plan, to control or direct payment to providers or adds any amount to the contracted payment rates which is considered in calculating the actuarially sound capitation rate, CMS will require compliance with 42 C.F.R. § 438.6(c) or (d). Moving forward, CMS will continue to monitor contract requirements described in the first scenario in light of the concerns raised with contract requirements in the second scenario.

To allow states time to amend their existing contract requirements, CMS will begin applying the regulation consistent with this guidance for contract rating periods that begin on or after July 1, 2021.

Basing Payment on the Utilization and Delivery of Services

State directed payments must be based on the delivery and utilization of services to Medicaid beneficiaries covered under the contract. CMS further clarifies that state directed payments need to be conditioned on the delivery and utilization of services covered under the contract for the applicable rating period. Therefore, state directed payments must be tied to utilization and delivery of services covered under the contract during the corresponding contract rating period; payment cannot be based solely on historical utilization. To be clear, in capitation rate development, states can use historical data to inform the rate that will be paid to managed care plans for services under the contract rating period; however, payment to providers must be made based on the delivery and utilization of covered services rendered to Medicaid beneficiaries during the applicable rating period.

[4] 81 Fed. Reg. at 27587-89.

In addition, CMS clarifies that the prior approval of a state directed payment under 42 C.F.R. § 438.6(c) provides authority for states to include such contract requirements directing a plan's expenditures in their managed care contract(s) and in the related rate certification(s), but it does not provide authority for a new benefit or service. States must have authority either as part of the state plan or through some other Medicaid authority (e.g., section 1115 demonstration, section 1915(c) waiver, etc.) to require their plans to cover the benefit or service linked to the state directed payment.

Prior Approval of State Directed Payments

Effective December 14, 2020, 42 C.F.R. § 438.6(c)(2) requires contract arrangements that direct the managed care plan's expenditures under § 438.6(c)(1)(i) and (ii) and (c)(1)(iii)(B) through (D) to have written approval from CMS prior to implementation. [5] Therefore, states must obtain written approval of state directed payments before approval of the corresponding Medicaid managed care contract(s) and rate certification(s). The regulation does not permit states to add new state directed payments for rating periods that have ended.

CMS remains committed to ensuring a timely review of state directed payment preprints. To help expedite the review process for state managed care contract(s) and rate certification(s), CMS strongly recommends that states submit preprints for state directed payments to CMS at least 90 calendar days in advance of the start of the rating period that includes the state directed payment. States should submit the preprint(s) to the following **new** mailbox:

StateDirectedPayment@cms.hhs.gov to ensure proper processing.

If a state has concerns or questions about a state directed payment (e.g., the state directed payment is new), CMS encourages seeking technical assistance prior to incorporating such directed payments into contract(s) and rate certification(s); such actions can help to facilitate the subsequent review of Medicaid managed care contract(s) and rate certification(s).

State Directed Payment Levels

All contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under 42 C.F.R. § 438.6(c)(1)(i) through (iii) must be developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices. Under the definition in 42 C.F.R. § 438.4, actuarially sound capitation rates are "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract."

As part of ensuring that the final capitation rates paid to the plan are reasonable, appropriate, and attainable for the populations to be covered and the services to be furnished under the contract, as well as adequate to ensure access to care, CMS has required states to demonstrate that the state directed payments result in provider payment rates that are reasonable, appropriate, and

[5] Prior to December 14, 2020, 42 C.F.R. § 438.6(c)(2) required contract arrangements that direct the managed care plan's expenditures under § 438.6(c)(1)(i) through (iii) to have prior written approval. The regulation was amended by the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which appeared in the Federal Register on November 13, 2020. (85 FR 72754).

attainable as part of the review of the preprint. To do this, CMS has required an analysis from states to understand the relative effect of the directed payment on reimbursement for each service type and each provider class receiving the state directed payment(s). Specifically, this analysis must provide the average base rate paid by plans to providers absent the impact of state directed payments, the effect each state directed payment(s) has on reimbursement for the service type(s), and any additional effects of permissible pass-through payments on reimbursement using a standardized measure (e.g., as a percent of Medicare or the Medicaid state plan rate). This analysis must be specific to each service type included in the state directed payment and specific to each provider class identified. For example, if a state directed payment provides a uniform increase for inpatient and outpatient hospital services with two provider classes (rural hospitals and non-rural hospitals), then states must provide CMS the following information:

Provider Class	**Average Base Rate Paid by Plans**	**Effect on Total Reimbursement (as a Percent of Medicare or Another Standardized Measure)**		
		Effect of State Directed Payment	Effect of Any Other State Directed Payments	Effect of Any Pass-Through Payments
Rural Hospitals – Inpatient Services				
Rural Hospitals – Outpatient Services				
Non-Rural Hospitals – Inpatient Services				
Non-Rural Hospitals – Outpatient Services				

To ensure appropriate oversight and prudent program management, CMS has initiated a review of state directed payments and may issue future guidance and/or rulemaking based on the findings of this evaluation. This review was initiated based on our experience reviewing state requests for state directed payments, as we have seen proposals for significant changes to provider reimbursement, which may in turn have an impact on program expenditures.

Provider Class Definition

State directed payments are required under 42 C.F.R. § 438.6(c)(2)(ii)(B) to direct expenditures equally, using the same terms of performance, for a ***class of providers*** providing the service under the contract. As stated in the May 2020 CIB, historically, CMS has deferred to states in defining the provider class for purposes of state directed payment arrangements, as long as the provider class is reasonable and identifiable, such as the provider class being defined in the state's Medicaid State Plan.

Regardless of how a state defines the provider class, the same terms of performance must be applied to all providers that are in that provider class. To clarify, this requirement does not require that each provider that meets the provider class definition earns the same total dollars for the delivery of services. If a state directed payment arrangement is a fee schedule requirement,

the fee schedule requirement would need to apply to the services provided by all providers that meet the class definition; however, the final amount earned by the provider would depend on the number of services provided.

For quality-based or value-based purchasing payments under 42 C.F.R. § 438.6(c)(1)(i) and (ii), the state directed payment arrangement would need to have the same terms of performance for all of the providers that are in the provider class. For example, for a state directed payment arrangement that was a pay for performance initiative, the same metrics and thresholds/benchmarks for earning the payment would apply to all the providers in the class. The amount each provider would earn would be based on each provider's individual performance.

Regardless of arrangement, the regulations at 42 C.F.R. § 438.6(c)(2)(ii)(E) require that the payments cannot be conditioned upon the provider entering into or adhering to intergovernmental transfer agreements. Additionally, states must provide an analysis of the reimbursement level with sufficient detail for CMS to understand the relative effect of the directed payment on total reimbursement for each service and each provider class receiving the state directed payment(s). This analysis will need to be specific to the provider class(es) defined in the state directed payment preprint. For example, if the state defined the provider class for a state directed payment as primary care physicians, the analysis of the reimbursement levels would need to be specific to primary care physicians; it should not include all physicians (primary care and specialty physicians).

Incorporation of State Directed Payments into Capitation Rates

All state directed payments must be incorporated into all applicable managed care contract(s) and described in all applicable rate certification(s) as noted in 42 C.F.R. § 438.7(b)(6). As part of the 2020-2021 Medicaid Managed Care Rate Development Guide, CMS provided guidance on two ways that states could incorporate state directed payments – either through adjustments to the base capitation rates as an adjustment to the rate or through a separate payment term.[6] The rate guide describes the documentation requirements for each option. Incorporating state directed payments as adjustments to the base capitation rates is consistent with the nature of risk-based managed care. Most states adopting minimum or maximum fee schedules incorporate these directed payments through adjustments to the base capitation rates. However, there are an increasing number of states that are now incorporating directed payments into their rate certification(s) through separate payment terms.

As CMS has reviewed state directed payments and the related rate certifications, CMS has identified a number of concerns around the use of separate payment terms. Frequently, while there is risk for the providers, there is often little or no risk for the plans related to the directed payment, which is contrary to the nature of risk-based managed care. This can also result in perverse incentives for plans that can result in shifting utilization to providers in ways that are not consistent with Medicaid program goals. To further enhance program integrity and financial oversight of state directed payments, CMS intends to require additional documentation and

[6] This guidance has appeared in the Medicaid Managed Care Rate Development Guide for rating periods starting between July 1, 2019 and June 30, 2021. Medicaid Managed Care Rate Development Guides for every rating period are located at: https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html.

justification from states as to their rationale for incorporating state directed payments through means other than adjustments to the base capitation rates as part of the preprint review.

Please note that CMS can provide technical assistance if a state has questions or concerns about how to include the impact of the payment arrangement in their Medicaid managed care rate certification(s). We also encourage states to consult the latest Medicaid Managed Care Rate Development Guide.

Financing of State Directed Payments

States can use permissible funding sources, including intergovernmental transfers and provider taxes that comply with federal statute and regulations to fund the non-federal share of state directed payments. Guidance provided in this SMDL is not intended to change this policy. However, approval of a state directed payment does not constitute approval of the financing mechanism for the non-federal share. States will need to work with the appropriate CMS staff to obtain the necessary approvals of a financing mechanism. Certain financing requirements in statute and regulation are applicable across the Medicaid program irrespective of the delivery system or program (that is, fee-for-service, managed care, state directed payments, demonstration authorities, etc.). Such requirements include, but are not limited to, limitations on financing of the non-federal share applicable to health care-related taxes, bona fide provider related donations, and intergovernmental transfers.

For states that are using intergovernmental transfers to fund, in part or in whole, the non-federal share of a state directed payment, 42 C.F.R. § 438.6(c)(2)(ii)(E) requires that states demonstrate in writing (except for minimum fee schedules using State plan approved rates) that the arrangement does not condition provider participation in contract arrangements that use state directed payments (that is, the contract and payment arrangements described in § 438.6(c)(1)(i) through (iii)) upon the provider entering into or adhering to intergovernmental transfer agreements.[7] To clarify, states can use intergovernmental transfers to fund the non-federal share of a state directed payment; however, states cannot limit either the provider's ability to participate in state directed payments or the amount the provider is eligible to obtain through the state directed payment based on the provider's participation in or adherence to an intergovernmental transfer. Similarly, provider classes cannot be defined or tailored to only include providers that provide intergovernmental transfers. If the provider meets the criteria for the provider class, the provider must be eligible to participate in the state directed payment arrangement regardless of whether the provider participates in any intergovernmental transfer agreements.

[7] Prior to December 14, 2020, 42 C.F.R. § 438.6(c)(2) required contract arrangements that direct the managed care plan's expenditures under § 438.6(c)(1)(i) through (iii) to have prior written approval. The regulation was amended by the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which appeared in the Federal Register on November 13, 2020 (85 FR 72754). Specifically, minimum fee schedules for network providers that provide a particular service under the contract using State plan approved rates as described in 42. C.F.R. § 438.6(c)(1)(iii)(A) do not have to obtain written approval prior to implementation though they still need to comply with the regulatory requirements for state directed payments as described in 42 C.F.R. § 438.6(c).

Quality and Accountability

42 C.F.R. § 438.6(c)(2) requires that directed payments be directly linked to quality improvement. Specifically, the regulations set forth the following three requirements that states must meet in order to receive CMS approval for their directed payment proposals:

(1) Each directed payment must be expected to advance at least one of the goals and objectives in the state's managed care quality strategy (QS)[8];
(2) Each directed payment must have an evaluation plan to measure the degree to which the arrangement advances at least one of the quality strategy goal(s) and objective(s)[9]; and
(3) For states electing to direct managed care plans to implement a value-based or delivery system reform payment arrangement, the directed payments must use a common set of performance measures across all payers and providers participating in the reform or improvement initiative.[10]

The November 2017 CIB provided further guidance on the quality requirements for state directed payment proposals. That CIB specified that the preprint should also include: the identification of performance criteria which can be used to assess progress on the specified goal(s) and objective(s); baseline data for performance measure(s); and improvement targets for performance measure(s). The November 2017 CIB also recommended that states look to measures already being collected, or that are widely available, and provided links to the Medicaid and CHIP Adult and Child Core Sets as well as other commonly used measure sets[11]. To facilitate the evaluation of state directed payment arrangements, the November 2017 CIB also suggested several ways that states may leverage activities they may already be undertaking, such as External Quality Reviews (EQRs), the use of consumer or provider surveys, or monitoring whether performance improves on key quality measures, in order to fulfill the evaluation requirement.

CMS is available to provide technical assistance to states for any of the quality requirements of directed payments.

Revised Preprint

To make submission of state directed payment preprints easier, more comprehensive, and to reduce processing time, CMS is releasing a revised preprint to be used for all state directed payment requests for contract rating periods that begin on or after July 1, 2021. Under 42 C.F.R § 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures

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[8] 42 C.F.R. § 438.6(c)(2)(ii)(C)
[9] 42 C.F.R. § 438.6(c)(2)(ii)(D)
[10] 42 C.F.R. § 438.6(c)(2)(iii)(B)
[11] Examples of measure sets in wide use across Medicaid programs include the Medicaid and CHIP Child Core Set (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set/index.html), the Medicaid Adult Core Set (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set/index.html#CoreSet), the Medicaid Health Homes Core Set (https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/quality-reporting/index.html), and the Core Quality Measure Collaborative sets (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html).

under paragraphs (c)(1)(i) and (ii) and (c)(1)(iii)(B) through (D)[12] must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). The revised preprint implements the prior approval process and must be completed, submitted to, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R § 438.6(c)(1)(i) and (ii) and (c)(1)(iii)(B) through (D). States may use the revised preprint for contract rating periods that begin before July 1, 2021 and will be required to use the revised preprint for all state directed payment reviews for contract rating periods that begin on or after July 1, 2021. This revised preprint includes more information in tables and check-box formats to make completing the preprint easier and clearer. Additionally, by including more information in the revised preprint, CMS hopes to reduce processing time by reducing the quantity of follow-up questions during CMS review.

Technical Assistance

As noted earlier, CMS has already approved state directed payment arrangements in many states and found that early discussions with states and technical assistance on completing the preprint are beneficial for both states and CMS during the review process. We encourage states to reach out early for technical assistance to expedite CMS' review of state proposals. Please contact us at StateDirectedPayment@cms.hhs.gov for technical assistance or questions. We look forward to continuing our partnership with you to deliver on our shared goals of providing high quality and sustainable healthcare to those who need it most.

Sincerely,

Anne Marie Costello
Acting Deputy Administrator and Director

[12] Prior to December 14, 2020, 42 C.F.R. § 438.6(c)(2) required all contract arrangements that direct the managed care plan's expenditures under § 438.6(c)(1)(i) through (iii) to have prior written approval. The regulation was amended by the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which appeared in the Federal Register on November 13, 2020 (85 FR 72754).

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Suite 900
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

August 3, 2020

Stephanie Stephens
Associate Commissioner, Medicaid/CHIP Division
State of Texas, Health and Human Services Commission
4900 Lamar Boulevard
Austin, TX 78751

Dear Ms. Stephens:

In accordance with 42 Code of Federal Regulations (CFR) 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Texas's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on February 28, 2020.

Specifically, the following proposal for delivery system and provider payment initiatives is approved:

- Quality Improvement Payment Program (QIPP) for the rating period covering September 1, 2020 through August 31, 2021.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

All state directed payments must be developed in accordance with 42 CFR 438.4, the standards specified in 438.5, and generally accepted actuarial principles and practices. Actuarially sound capitation rates are defined in 42 CFR 438.4 to be projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract. As part of ensuring that the final capitation rates paid to the plan are appropriate for the populations to be covered and the services to be furnished under the contract, as well as adequate to ensure access to care, CMS has required states to demonstrate that the state directed payments result in provider payment rates that are reasonable, appropriate, and attainable as part of the initial review of the preprint. While the state has provided some documentation to address this requirement, CMS will require more robust documentation for

future submissions. Specifically, this analysis must provide the average base rate paid by plans to providers absent the impact of state directed payments, the effect each state directed payment(s) has on reimbursement for the service type(s), and any additional effects of permissible pass-through payments on reimbursement using a standardized measure (e.g., as a percent of the rate Medicare paid, the Medicaid state plan rate paid per service, and/or the average commercial rate paid for such services). This analysis must be specific to each service type included in the state directed payment (nursing facility services) and specific to each provider class identified (non-state government owned nursing facilities and private nursing facilities). If the state has questions or concerns about the level of documentation needed to comply with this language, CMS is available for technical assistance.

CMS also notes its concerns with the measures included in Component 4, which addresses infection control. CMS believes that this is a critical area of focus and has made recommendations for additional measures that the state should consider for the future. CMS expects the state to include additional measures from those recommended during this year's review as part of the preprint proposal for SFY 2022.

CMS also believes that infection control is important for all nursing facilities (non-state government-owned as well as private nursing facilities). CMS encourages the state to make both provider types eligible under Component 4 or include infection control measures in another component open to all nursing facilities.

CMS continues to note that the allocation of funds under Component 1 continues to raise concerns about the link to utilization, delivery of services or quality under the contract. Specifically, if the state continues to pay this component as a uniform increase, CMS expects the state to move away from a reconciliation requirement and instead require plans to pay based on the actual facility bed days during the contract rating period. CMS is happy to provide technical assistance as the state considers revisions to this payment arrangement.

Additionally, CMS is approving this payment arrangement with the understanding that the state will submit an updated quality strategy to CMS no later than May 2021 and provide complete Year 3 (SFY 2020) evaluation results with the submission of the Year 5 (SFY 2022) preprint. Lastly, please note that this payment arrangement must be addressed in the applicable rate certifications. CMS is happy to provide technical assistance to states and their actuaries.

If you have questions concerning this letter, please contact Laura Snyder, Division of Managed Care Policy, at (410) 786-3198.

Sincerely,

Bill Brooks, Director
Division of Managed Care Plan Operations

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

November 15, 2021

Stephanie Stephens
Associate Commissioner, Medicaid/CHIP Division
Medical and Social Services
State of Texas, Health and Human Services Commission
4900 Lamar Boulevard
Austin, TX 78751

Dear Ms. Stephens:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Texas' submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on March 11, 2021 and determined complete on March 24, 2021. A final revised proposal was received on October 13, 2021 and has a control name of TX_VBP_NF_Renewal_20210901-20220831.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e., state directed payment) is approved:

- Quality Improvement Payment Program (QIPP) for the rating period covering September 1, 2021 through August 31, 2022.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All relevant federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

Based on the information provided by the state (including the state's commitment to implement appropriate ongoing oversight and monitoring of its non-federal share financing sources), the non-federal share sources relating to the QIPP state directed payment program appear to meet non-federal share financing requirements in section 1903(w) of the Social Security Act (the Act) and implementing regulations in 42 CFR Part 433. To the extent CMS later discovers (either though further CMS review or review by a third party such as the HHS OIG or state auditor) that these QIPP financing arrangements do, in fact, violate section 1903(w) of the Act or its implementing regulations, CMS may enforce compliance by initiating deferrals and/or disallowances of federal financial participation.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

CMS appreciates the state's revisions to the QIPP state directed payment, particularly reducing the reconciliation threshold for Component 1 to zero percent (effectively eliminating it). As CMS expressed in the approval letter last year issued August 3, 2020, the payments under Component 1 previously had been based on historical utilization, which raised concerns about the link to utilization, delivery of services or quality under the contract. In the State Medicaid Directed Letter issued January 8, 2021, CMS further clarified our policy that "state directed payments need to be conditioned on the delivery and utilization of services covered under the contract for the applicable rating period. Therefore, state directed payments must be tied to utilization and delivery of services covered under the contract during the corresponding contract rating period; payment cannot be based solely on historical utilization.…. payment to providers must be made based on the delivery and utilization of covered services rendered to Medicaid beneficiaries during the applicable rating period." CMS believes the changes made to the SFY 2022 preprint for QIPP address this long-standing issue. If the state continues to pay this component or any portion of this payment as a uniform increase in the next rating period, CMS expects payment will continue to be based on utilization rendered during the applicable rating period (e.g., for the SFY 2023 rating period, payments will need to be conditioned upon the delivery and utilization of covered services rendered to Medicaid beneficiaries during the SFY 2023 rating period). If the state chooses to continue to include a reconciliation requirement, this would mean that the reconciliation requirement would remain at zero percent. CMS will not approve the state directed payment if Component 1 or other parts of the payment arrangement condition payment on services rendered during a previous rating period; the requirement of a reconciliation threshold or similar structure with a threshold higher than zero percent will not be considered sufficient to meet this regulatory requirement. If the state would like to discuss other changes to this program, CMS is happy to provide technical assistance.

For Components 3 and 4, CMS also appreciates that the state incorporated changes to the payment arrangement to ensure that only facilities that maintain or improve performance on the identified metrics will receive payments under these components. If the state continues this payment arrangement for the SFY 2023 rating period or any future rating periods, CMS expects that such safeguards are maintained to continue ensuring that payments under any component conditioned upon performance only go to those facilities and providers that maintain or improve performance from one period to the next and not to providers that show declines in performance.

CMS also appreciates that the state revised its evaluation plan to refine the evaluation questions, measures, and analytic methods for the QIPP state directed payment. As a reminder, future evaluation plans must ensure that the results can be attributed to providers participating in this specific state directed payment and the Medicaid managed care beneficiaries receiving services from the nursing facilities eligible for the preprint. Additionally, the state must use consistent baseline data evaluations to demonstrate year over year changes. Baseline data should be submitted to CMS no later than six months after the end of the reporting year. CMS will provide technical assistance to the state as they make revisions for this payment arrangement for the next rating period.

If you have questions concerning this approval or state directed payments in general, please contact Juliet Kuhn, Division of Managed Care Policy, at (410) 786-2480, or juliet.kuhn@cms.hhs.gov.

Sincerely,

John Giles Digitally signed by John Giles
Date: 2021.11.15 19:41:02 -05'00'

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   September 1, 2021 - August 31, 2022
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* September 1, 2021
3. Identify the managed care program(s) to which this payment arrangement will apply:
   STAR+PLUS Nursing Facility
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $1,100,000,000
   a. Identify the estimated federal share of this state directed payment: $692,450,000
   b. Identify the estimated non-federal share of this state directed payment: $407,550,000

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:
   a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.
   b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.
      i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
      TX State Fiscal Years 2018, 2019, 2020, 2021
   c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
      ☐ Payment Type Change
      ☐ Provider Type Change
      ☒ Quality Metric(s) / Benchmark(s) Change
      ☒ Other; please describe:
      Percent allocation in two of four components
      ☐ No changes from previously approved preprint other than rating period(s).
7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

   See Attachment A

   a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
   b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

      See Attachment A

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☒ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

See Attachment B

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a. See Attachment C						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

See Attachment D

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

See Attachment D

c. For state-developed measures, please briefly describe how the measure was developed?

See Attachment D

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☒ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

Component 1 funds are based on 110% of the non-federal share for all participating public facilities.

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

Component 1 is paid monthly upon submission of required documentation.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

Component One is contingent upon proper submission of a Quality Assurance and Performance Improvement Validation Report form and data related to a NF-specific performance improvement project (PIP). Non-State Government-Owned Nursing Facilities (NSGOs) have an intrinsic responsibility to improve public health that's demonstrated through the quality assurance reporting required to meet the metric.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☒ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Non-state government-owned nursing facilities and private nursing facilities

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Non-state government-owned NF--A network nursing facility where a non-state governmental entity located in the state of Texas holds the license and is a party to the NF's Medicaid provider enrollment agreement with the state.

Private NF--A network nursing facility not owned by a governmental entity located in the state of Texas and holds a license.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

Prior to the beginning of the program period, HHSC identifies funds associated with each QIPP-enrolled NF broken down by QIPP capitation rate component, quality metric, and payment period. Cost report historical units of service are used to determine the distribution of QIPP funds across eligible and enrolled NFs. The NF must have had at least one Medicaid client in the care of that NF for each reporting period to be eligible for payments. For purposes of the calculations, each quality metric will be allocated an equal portion of the total dollars included in the component. In situations where a NF does not have enough data for a quality metric to be calculated, the funding associated with that metric will be evenly distributed across all remaining metrics within the component. HHSC will specify the performance requirement that will be associated with the designated quality metric. Achievement of performance requirements will trigger payments for the QIPP capitation rate components. Funds that are non-disbursed due to failure of one or more NFs to meet performance requirements will be distributed across all QIPP NFs based on each NF's proportion of total earned QIPP funds from Components One, Two, Three, and Four combined.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Non-State Government Owned	70.65%	29.35%	0.00%		100.00%
b. Privately Owned	78.12%	21.88%	0.00%		100.00%
c.	0.00%	0.00%	0.00%		0.00%
d.	0.00%	0.00%	0.00%		0.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☒ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The data source used to determine the average base payment level was the 2018 Nursing Facility Medicaid Cost Report, with utilization trended to 2021. The data source used to determine the state directed payments was the estimated QIPP 2021 payments.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

To ensure that QIPP funds are focused on the Medicaid population, HHSC will limit private nursing facility eligibility to nursing facilities with a percentage of Medicaid nursing facility days of service greater than or equal to 65 percent. The payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers providing the service under the contract. Payments of allocated funds will be triggered based on either the attainment of benchmarks or on demonstrated improvement in selected quality metrics, which will be equally weighted within each of the four components. Non-dispersed funds due to a NF's failure to achieve a metric will be redistributed across all NFs in proportion to their percentage of the total funds earned.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☒ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

HHSC will provide the managed care contracts 45 days prior to the effective date.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☒ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

07/18/2021

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☒ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

N/A

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. See Attachments F and F-1					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

There are no written agreements between HHSC and healthcare providers participating in QIPP regarding QIPP. The state currently collects information from units of local government that provide IGTs to the state to ensure compliance with all federal regulations. Texas began to implement large scale monitoring of the non-federal share several months ago. Texas continues to refine its monitoring mechanisms.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficie
- **b.** The effective date of quality strategy. July 31, 2021

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a.		Page 2
b.		Page 2
c.		Page 3
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

Component One: QIPP advances Goal 2 by incentivizing quality improvement for participating NFs by attaching funds to exceeding federally mandated QAPI meetings and requiring NFs to develop a data-driven facility-specific performance improvement project (PIP) on MDS Five-Star Long-Stay quality metrics.
Component Two: Facilities must maintain additional four or eight RN hours per day beyond the CMS mandate of eight hours. Further, facilities must also develop a facility-specific PIP to improve staff recruitment, retention, and other workforce outcomes. Research demonstrates that additional RN and staff coverage enhances quality of care (including patient safety), addressing Goal 1.
Components Three and Four: QIPP will further both Goal 1 objectives through quality metrics relating to six Minimum Data Set CMS Long-Stay Quality Measures. NFs can achieve this goal by either meeting or exceeding the national average or by showing an improvement in their baselines for pressure ulcers (CMS N015.03), antipsychotic medication (CMS N031.03), mobility (CMS N035.03), UTIs (CMS N024.02), Pneumococcal Vaccine (CMS N020.02), and Seasonal Influenza Vaccine (CMS N016.03).
Component Four: Addressing Goal 2, staged performance targets will require NFs to assess their infection control and antibiotic stewardship policies and engage NF leadership in infection prevention by requiring the Nursing Facility Administrator and Director of Nursing to complete a training course developed by CMS and the Centers for Disease Control and Prevention (CDC).

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. See Attachment I, QIPP Evaluation Plan				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

See Attachment H- Evaluation Report for the Quality Incentive Payment Program for Nursing Facilities (SFY 2018 – 2020).
See Attachment I- QIPP Evaluation Plan SFY2022-24

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

November 15, 2021

Stephanie Stephens
Associate Commissioner, Medicaid/CHIP Division
Medical and Social Services
State of Texas, Health and Human Services Commission
4900 Lamar Boulevard
Austin, TX 78751

Dear Ms. Stephens:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Texas' submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on March 25, 2021 and determined complete on April 1, 2021. A final revised proposal was received on October 15, 2021 and has a control name of TX_Fee_Oth_New_20210901-20220831.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e., state directed payment) is approved:

- Behavioral Health Services (BHS) directed payment program for the rating period covering September 1, 2021 through August 31, 2022.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All relevant federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

Based on the information provided by the state (including the state's commitment to implement appropriate ongoing oversight and monitoring of its non-federal share financing sources), the non-federal share sources relating to the BHS state directed payment program appear to meet non-federal share financing requirements in section 1903(w) of the Social Security Act (the Act) and implementing regulations in 42 CFR Part 433. To the extent CMS later discovers (either though further CMS review or review by a third party such as the HHS OIG or state auditor) that these BHS financing arrangements do, in fact, violate section 1903(w) of the Act or its implementing regulations, CMS may enforce compliance by initiating deferrals and/or disallowances of federal financial participation.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in

the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

CMS appreciates the state's revisions to the BHS state directed payment, particularly reducing the reconciliation threshold for Component 1 to zero percent (effectively eliminating it). As originally submitted, Component 1 had been based on historical utilization, which raised concerns about the link to utilization and delivery of services under the contract. In the State Medicaid Directed Letter issued January 8, 2021, CMS further clarified our policy that "state directed payments need to be conditioned on the delivery and utilization of services covered under the contract for the applicable rating period. Therefore, state directed payments must be tied to utilization and delivery of services covered under the contract during the corresponding contract rating period; payment cannot be based solely on historical utilization.…. payment to providers must be made based on the delivery and utilization of covered services rendered to Medicaid beneficiaries during the applicable rating period." CMS believes the changes made to the SFY 2022 preprint for BHS address this issue. If the state continues to pay this component or any portion of this payment as a uniform increase in the next rating period, CMS expects payment will continue to be based on utilization rendered during the applicable rating period (e.g., for the SFY 2023 rating period, payments will need to be conditioned upon the delivery and utilization of covered services rendered to Medicaid beneficiaries during the SFY 2023 rating period). If the state chooses to continue to include a reconciliation requirement, this would mean that the reconciliation requirement would remain at zero percent. CMS will not approve the state directed payment if Component 1 or other parts of the payment arrangement continue to base payment on services rendered during a previous rating period; the requirement of a reconciliation threshold or similar structure with a threshold higher than zero percent will not be considered sufficient to meet this regulatory requirement.

CMS also appreciates the changes the state made to Component 2 of the payment arrangement to ensure an appropriate tie to utilization and the delivery of services under the Medicaid managed care contract for the SFY 2022 rating period. Please also note that if the state seeks to transition any part of this payment arrangement into a value-based payment arrangement where payment is conditioned upon performance, it will need to ensure that the performance measurement period overlaps with the rating period. The state cannot condition payment upon reporting of data; payment must be conditioned on the delivery and utilization of services. CMS is happy to provide technical assistance for any future changes the state wishes to make to the state directed payments.

CMS appreciates that the state revised its evaluation strategy to isolate the impact of the BHS state directed payment from other state directed payments that the state is pursuing for this rating period. As a reminder, future evaluation plans must ensure that the results can be attributed to providers participating in this specific state directed payment and the Medicaid managed care beneficiaries receiving services from the community mental health centers eligible for the preprint. Additionally, the state must use consistent baseline data evaluations to demonstrate year over year changes. Baseline data should be submitted to CMS no later than six months after the end of the reporting year. CMS will provide technical assistance to the state as they make revisions for this payment arrangement for the next rating period.

If you have questions concerning this approval or state directed payments in general, please contact Juliet Kuhn, Division of Managed Care Policy, at (410) 786-2480, or juliet.kuhn@cms.hhs.gov.

Sincerely,

John Giles Digitally signed by John Giles
Date: 2021.11.15 19:41:38 -05'00'

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   September 1, 2021 - August 31, 2022
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* September 1, 2021
3. Identify the managed care program(s) to which this payment arrangement will apply:
   STAR, STAR+PLUS, STAR Kids. See Attachment A for the risk groups associated with each program.
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $176,400,019
   a. Identify the estimated federal share of this state directed payment: $111,043,812
   b. Identify the estimated non-federal share of this state directed payment: $65,356,207

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☒ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:
   a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.
   b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.
      i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

   c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
      ☐ Payment Type Change
      ☐ Provider Type Change
      ☐ Quality Metric(s) / Benchmark(s) Change
      ☐ Other; please describe:

      ☐ No changes from previously approved preprint other than rating period(s).
7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

   Please see Attachment B - Question 8.

   a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
   b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

      https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/state-plan

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☒ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

Please see Attachment E

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

Please see Attachment E

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

Please see Attachment E

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☒ Other: Community Mental Health Centers (CMHCs)

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

There will be 2 classes of providers in this program: 1) CMHCs with CCBHC certification and 2) CMHCs without CCBHC certification.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

DPP BHS aligns the goals of CCBHCs within the current Medicaid and behavioral health environment in Texas and demonstrates a commitment to using CCBHCs as a best practice for behavioral health service delivery. Starting in Fiscal Year 2020, HHSC began increasing the number of CCBHCs statewide to expand capacity for community-based behavioral health services and enhance behavioral health care outcomes.

While CMHCs can enroll in the program regardless of the certification status, HHSC proposes establishment of two classes to incentivize CMHCs to receive CCBHC certification and maintain it in future years. The higher percentage increase for providers with CCBHC certification in Component 2 recognizes the increased operating costs of the model and provides an incentive for those not yet certified to attain certification.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

A. For Component 1, payments will be based on the same units by procedure code across all providers based on each CMHC's SFY19 utilization with a final reconciliation. Each CMHC will receive the same payment increase per unit.
B. For Component 2, the uniform percent increases will be consistent across a) CMHCs without certification and b) CMHCs with CCBHC certification. Certified CMHCs receive a higher percentage increase compared to non-certified CMHCs, as the CCBHBC model has additional costs related to providing whole person care.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. CMHCs w/o certification	37.00%	54.00%			91.00%
b. CMHCs w/CCBHC certification	40.00%	55.00%			95.00%
c. Total	40.00%	56.00%			96.00%
d.	0.00%	0.00%			0.00%
e.	0.00%	0.00%			0.00%
f.	0.00%	0.00%			0.00%
g.	0.00%	0.00%			0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: Percentage of CMHC Cost Report PPS-2 Rate (see question 27 for details)

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Please see Attachment G.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

CMS has provided the state with feedback that reimbursing certified CMHCs utilizing the PPS-2 rates under the CCBHC demonstration model could be considered as the comparison point for a Directed Payment Program incentivizing the CCBHC model of care. The program is designed to reimburse the participants the difference between the PPS-2 rates and MCO payments. Please see question 19.d response for additional detail.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☒ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

HHSC will provide the managed care contracts 45 days prior to the effective date.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☒ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

12/01/2021

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☒ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

N/A

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. See Attachment H					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

There are no written agreements between HHSC and healthcare providers participating in DPP BHS regarding DPP BHS. The state currently collects information from units of local government that provide IGTs to the state to ensure compliance with all federal regulations. Texas began to implement large scale monitoring of the non-federal share several months ago. Texas continues to refine its monitoring mechanisms.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: See Attachment I
- **b.** The effective date of quality strategy. September 9, 2021

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a.		1
b.		2
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.
Please see Attachment J - DPP BHS Question 43

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Please refer to the Evaluation Plan for Year 1 (SFY2022) of Four New State Directed Payments (DPP Evaluation Measures section)				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

The Present and Future of Medicaid

Presenter - David Salsberry

August 17, 2017

Discussion Agenda

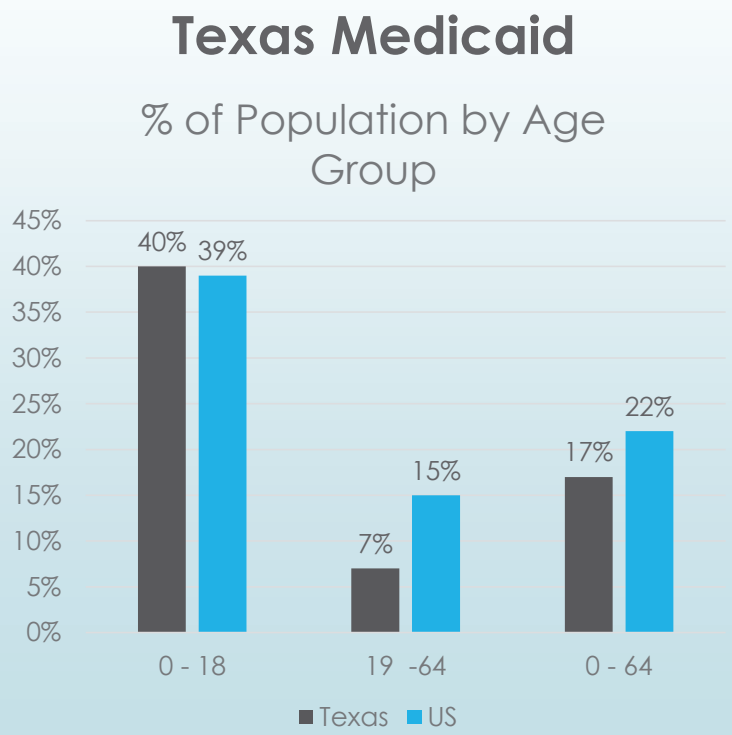
- Federal Push to Reduce Medicaid Funding
- Quick Primer on how Texas Medicaid is Funded
- Texas Medicaid - Current Areas of Focus
- Future Challenges
  - 1115 Waiver Renewal
  - UC Disallowance
- New Opportunity
  - LPPF
  - UHRIP
- Concluding Thoughts

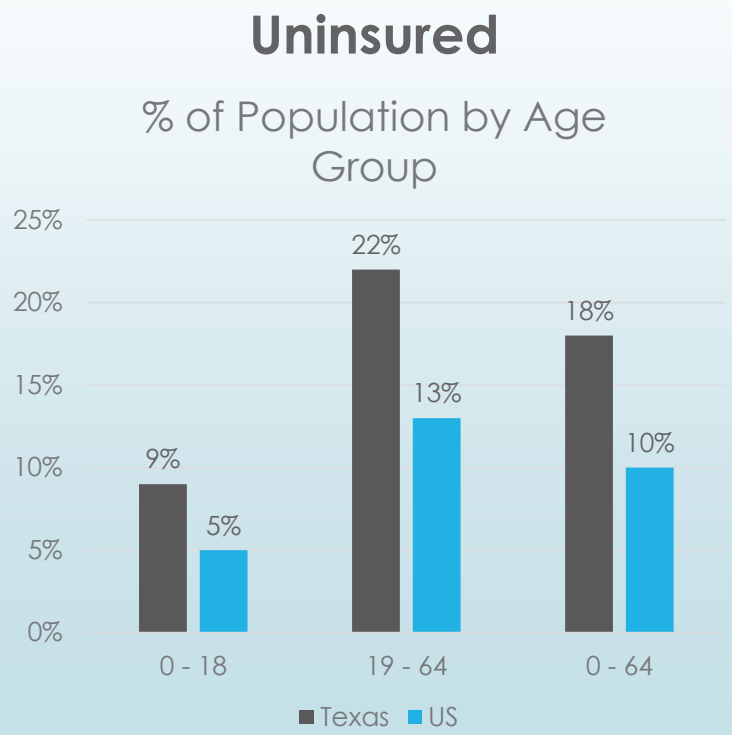
Texas Medicaid Perspective – Health Coverage

	Age 0 to 18	Age 19 to 64	Total – Age 0 to 64
Employer	3,298,300	9,522,200	12,820,500
Non-Group	383,600	1,393,400	1,777,000
Medicaid	3,002,400	1,170,200	4,172,600
Other Public	224,500	835,200	1,059,700
Uninsured	691,200	3,568,000	4,259,200
Total	7,600,000	16,489,000	24,089,000

Source: Kaiser Family Foundation, 2015

% of Population Covered by Medicaid or Uninsured – Texas vs U.S.





Source: Kaiser Family Foundation, 2015

Medicaid Program Financing Background

- Medicaid **is jointly financed** by states and the federal government.
- Medicaid **enrollment varies** significantly among states based on each state's decision to expand or not expand Medicaid as a result of the ACA.
- States and the federal government **share in the financing** of the Medicaid program. Under federal Medicaid law, the federal government pays between 50 and 74 percent of all the costs of providing services to beneficiaries under the program.
- How do providers receive payment for providing services for Medicaid patients? Most states pay for Medicaid services through **fee schedules** or though risk arrangements with managed care organizations who contract with providers. These payments are typically below the cost of care for a health care provider.
- Fee schedules in Texas reimburse approximately **55% to 65%** of the total cost of care
- Medicaid **supplemental payments** and grants are used as an enhancement to fee schedule payments.
- Medicaid also partially **funds services to medically indigent (UC) patients**, who are not enrolled in Medicaid, through supplemental payments.

Texas Medicaid Funding Overview

Federal	State	Texas $
• 58.9%	• 41.1%	
• 62.8%	• 37.2%	

$21.1B + $14.7B = $35.8B

Source: Kaiser Family Foundation, 2015

Texas Dependence on Medicaid Supplemental Payment Programs

1115 Waiver

- DSRIP $3.1 billion (DY5-2016)
- UC $3.1 billion (DY5-2016)
- Hospitals, MHMR, MD's/AMC, Public Health

DSH

- $1.8 billion (DY5-2016)
- High Medicaid / Safety Net Hospitals
- Funded largely by 6 public hospitals

MPAP/QIPP

- $535 million (DY5-2016)
- Long Term Care
- Funded through complex ownership arrangements with an IGT provider

NAIP

- $527 million (DY5-2016)
- Designated AMC's & public hospitals
- Similar to DSRIP but focused on expanding access

Inter-Governmental Transfer (IGT) Defined

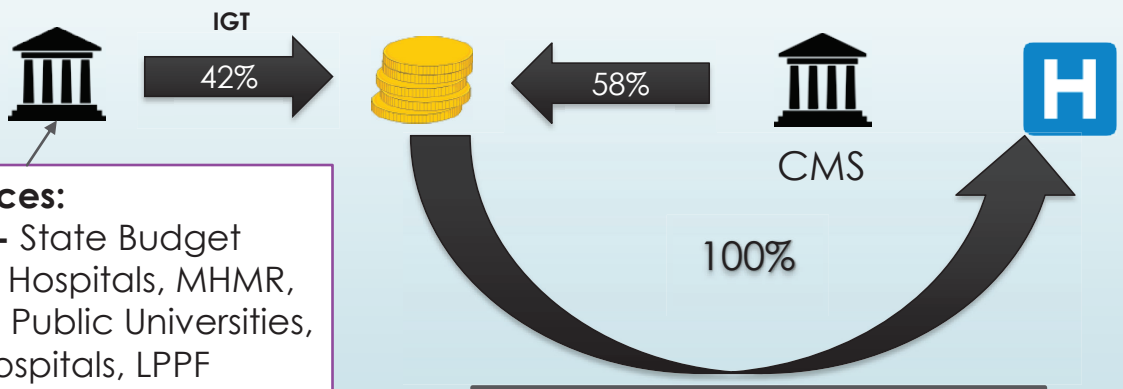
- **IGT's** (Intergovernmental Transfer) are used to fund various supplemental payment programs
- **IGT -** The process used to transfer funds between;
  - the Federal government
  - any unit of local government (including, but not limited to, a public hospital, hospital district, county, city, or Local Mental Health Authority); or
  - any state agency
- **IGT Source –** Must come from a qualifying governmental entity and can only come from qualifying revenues of the governmental entity.
- **FMAP -** Each state's IGT program has a specific matching percentage called the Federal Medical Assistance Percentage (FMAP). This is a percentage amount that the federal government will match when a state provides its portion (referred to as the state share). The percentage amount is established annually and varies from state to state depending on the state's per capita income.
  - For the state of California the FMAP is 50%, or an exact match. This means that for every 1 dollar the state funds, the federal government will also fund 1 dollar.

Challenges with Setting Up and Funding Supplemental Payment Programs

- **Funds Available to Pay Providers**
  - CMS and State agreement on funding pool size (i.e., 1115 Waiver, DSH, UPL, etc.), program requirements, and funds flow methods/ requirements (i.e., MCO pass through rules)
  - Budget neutrality calculation
- **Funds Available to Finance IGT's**
  - Source
  - Available Funds (IGT capacity test)
- **Working capital management of funds. Is the cash available when IGT's are due and payable?**
- **Congressional oversight** (GAO report) and Political Influence

Federal Matching Process

Illustration of Medicaid Federal Matching for Texas:



Qualifying Sources:
- **FFS Payments-** State Budget
- **DSRIP -** Public Hospitals, MHMR, Public Health, Public Universities,
- **UC –** Public Hospitals, LPPF funds, County Governments, Community Benefit / Burden Alleviation Model
- **DSH –** Large Public Hospitals

Payment based on Program Rules within each CMS approved program

Texas Medicaid – Current Areas of Focus

- **Figuring out CMS Priorities and Direction**:
  - **UC Funding** is not a long term solution /expanded coverage is a long term solution
  - Medicaid programs should pay **adequate FFS rates**
  - **Managed care integration** – programmatic and supplemental payments
  - **Recent CMS decisions** regarding Florida supplemental payments
- **1115 Waiver Extension** (incl. Extension of the Extension)/Renewal
  - UC Pool Size/Continuation
  - DSRIP Program Development – Transition from an "**infrastructure/ramp up**" focus on targeted "**projects**" to entity performance on "**measured bundles**" of care
- **Shift of IGT Financing:**
  - **CMS Disallowance** of Community Benefit Intergovernmental Transfer (IGT) Financing Model
  - Use of **Local Provider Participation Funds** (Provider Fee's) to fund enhanced Medicaid Payments

Texas Medicaid – Future Areas of Focus

- Federal Health Reform / ACA Repeal and/or Replace – dead or alive?
- ACA
  - Health Insurance Marketplace/Exchange – Limited impact in Texas due to withdrawal of most insurance companies
- Future IGT Financing Option - Local Provider Participation Funds
- Future FFS Rate Enhancement Option - Uniform Hospital Rate Improvement Program

Financing and Enhancing Medicaid Payment Rates

Texas Medicaid – What is an LPPF and how is it used ?

- LPPF is an IGT financing mechanism, not a reimbursement program
- Local Provider Participation Funds ("LPPF") provide Inter-Governmental Transfer (IGT) to access federal matching funds for Medicaid Supplement programs including UC, DSRIP, and UHRIP
- LPPF program is effectively an assessment on total net patient revenues (NPR) on the nonpublic hospitals within a county. The assessment cannot exceed 6% of NPR
- In Texas, state legislation is required for granting a "local option" that provides the public hospital or other government authority to administer an LPPF assessment on the nonpublic hospitals
- Prior to the 2017 legislative session, LPPF bills have been approved in 11 rural counties in Texas for funding UC and DSRIP payments
- LPPF bills were approved for 8 additional urban counties in the most recent legislative session and included LPPF bills for Dallas and Tarrant Counties

Local Provider Participation Fund (LPPF) History in Texas

- **LPPF BACKGROUND**
- During the 83rd and 84th sessions, the Texas Legislature overwhelmingly passed legislation that granted 11 counties and the city of Beaumont the flexibility and local choice to create Local Provider Participation Funds
  - The hospitals in these communities received millions of additional dollars in Medicaid UC and DSRIP payments as a result; those dollars otherwise would have gone elsewhere
- The LPPF provides a stable revenue stream to support the non-federal share of Medicaid Payments
  - Unlike other funding mechanisms, the level of IGT generated by the LPPF is predictable and reliable
- The 85th Legislature passed LPPF legislation for Dallas and Tarrant County, and the Dallas and Tarrant County Hospital Districts are currently in the early stages of implementing LPPFs

Federal Rules Regarding the LPPF

- The LPPF is consistent with CMS rules regarding provider taxes
  - Broad-based: The tax must apply to every hospital in the county that provides inpatient care
  - Uniform: The same tax rate must apply to all providers subject to the tax
  - No hold harmless: No unit of government may guarantee that a paying provider is held harmless for all or any portion of the funds paid into the LPPF
- Because CMS rules require that the LPPF be uniform and broad-based, some hospitals will pay more into the LPPF than they receive in benefit in the form of an increased Medicaid payment
  - Hospitals that have little or no Medicaid volume, or are not eligible for additional Medicaid payments through the state's Section 1115 waiver will not receive a direct benefit from the payments that the LPPF generates
    - These hospitals are referred to as net loss hospitals

Community Benefit Payments

- Net benefit hospitals ensure that net loss hospitals benefit through a **community benefit payment** directly from one of a number of the benefiting hospitals
  - This arrangement does not violate the hold **harmless prohibition** because the prohibition only applies to units of government; it does not prohibit hospitals that benefit from the tax from agreeing to make payments to net loss hospitals
  - The community benefit payment **fosters political support** for the LPPF among the local hospitals by ensuring that all hospitals benefit from the program
- In existing regions, the community benefit payment is generally equal to **105 percent** of the amount the Mandatory Payment, and is paid to the net loss hospital within 30 days after the net loss hospital makes its mandatory payment
  - In exchange, the net loss hospital's agrees:
    - to use that money to **enhance the provision of high-quality health care** services to patients in the County;
    - **to support imp**lementation of Mandatory Payments by the County; and
    - to **timely pay** the Mandatory Payments as required by the county
- The LPPF only works if everyone that is subject to the fee ends up with a benefit
- It's important to note that the **government entity is not a party to the grant agreement**

Texas Medicaid – Uniform Hospital Rate Increase Program ("UHRIP")

- **UHRIP is a hybrid reimbursement program.** The program has had a tough start getting traction in Texas
- THHSC is currently seeking approval from CMS to implement the UHRIP for hospital services in SFY beginning September 1, 2017
- If approved, hospital providers in an designated region (called a Service Delivery Area (SDA)), would see significant increases to **rates paid** by **Medicaid Managed Care Organizations** (MCO) for Rate increases may be allowable up to 95% of costs
- This rate increase would **reduce hospitals' Medicaid shortfall** in the managed care service delivery areas in which the program is implemented and **reduce dependence on shrinking UC payments**
- **Proposed rates** by class have been submitted to HHSC for the Dallas and MCO regions

Texas Medicaid – Uniform Hospital Rate Increase Program ("UHRIP")

- HHSC is currently calculating the available rate increases based on several factors including: MCO enrollment changes; fees for Medicaid MCO administration, risk pools, and other fees; IGT sufficiency; 95% Medicaid shortfall threshold, actuarial trending factors; and estimated budget neutrality impact
- HHSC must submit calculated rates to CMS for approval prior to program implementation
- Requires a sponsoring governmental entity:
  - JPS for the Tarrant County SDA
  - Parkland for the Dallas County SDA
- Medicaid managed care participation negotiations are in progress

Texas Medicaid – Local MCO Service Areas

- **Tarrant County MCO Service Area**
  - Tarrant
  - Denton
  - Wise
  - Parker
  - Hood
  - Johnson

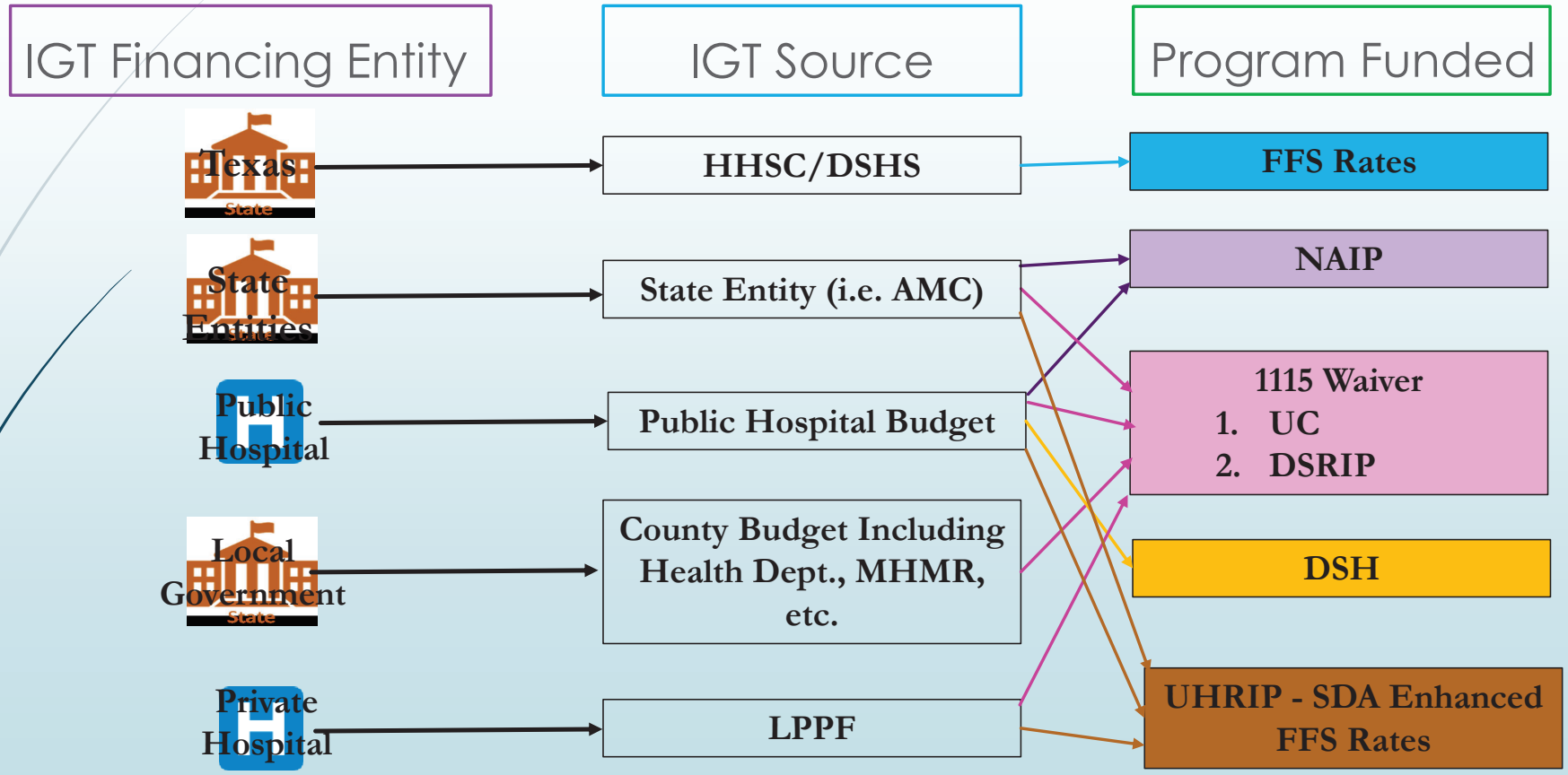
- **Dallas County MCO Service Area**
  - Dallas
  - Collin
  - Hunt
  - Rockwall
  - Kaufman
  - Ellis
  - Navarro

Texas Medicaid - LPPF / UHRIP Distribution Methodology of SDA's Shareable Net Benefit

1. The SDA benefit calculation is based on most recent available data at time of settlement.
2. Eligibility for an affiliate distribution requires all LPPF mandatory payments are paid on agreed upon date to pay to fully fund the necessary IGT.
3. Hospital Specific Benefit Calculation:
   a. The benefit is the difference between the increased UHRIP MCO payments (inclusive of the MCO quality payment gain/loss) and expenses.
   b. Expenses include applicable LPPF mandatory payment, MCO expenses, UC loss/gain, DSH loss/gain, LPPF administration expense, and grant expense (Base Grant + 5% Incentive Payment).
   c. Grant expense is for mitigation of private hospitals that incur a negative net benefit due to LPPF fee's in excess of UHRIP payments.
   d. Adjustments will be made in the event that secondary or substitute IGT sources are used to fund HHSC approved UHRIP MCO payments.
4. The remaining shareable net benefit is spread to all remaining non-public UHRIP participants based on an agreed upon allocation method (i.e., % share of UHRIP payments).

Concluding Thoughts

Medicaid Program Funds Flow for Hospitals



Change is Hardest in the Middle

Kanter's Law:

Everything looks like a failure in the middle. Everyone loves inspiring beginnings and happy endings; it is just the middles that involve hard work.

by Rosabeth Moss Kanter

- **Where do we go from here?**
  - **Tune into the environment**
  - **Check the vision**
  - **Test support**
  - **Examine progress**
  - **Search for synergies**

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Attachment B – Oversight and Monitoring Plan for Local Funds Used in Medicaid in Texas

Background:

For the Texas State Fiscal Year 2020, Texas Health and Human Services system published the Blueprint for a Healthy Texas, a business plan to guide activities. Included in that plan was an initiative related to supplemental and directed-payment programs with the goal described below:

Goal 1: Increase Oversight and Monitoring of Local Funding Structures

Improve accountability over the transfer of locally derived government funds by increasing oversight and monitoring of local funding structures.

Strategy

In FY 2020, more than $10 billion in Medicaid payments will be made in Texas through supplemental and directed payment programs. To receive federal reimbursements for Medicaid services, public dollars from local governments are used as matching funds. HHS supports implementation and provides oversight of local fund transfers, including those of governmental agencies that operate Local Provider Participation Funds (LPPFs).

The federal government restricts the types of funds that can be used for the matching share of a Medicaid payment and requires HHS to ensure those conditions are met.

To improve oversight of local fund transfers, HHS is developing reporting mechanisms and implementing enhanced monitoring strategies.

HHS will also develop rules and an online reporting portal for governmental entities that operate LPPFs. We will assess how ongoing monitoring should occur for all other sources of the non-federal share of supplemental and directed payment programs.

Deliverables Deliverable	**Target Completion**
Implement reporting rules for governmental entities that operate LPPFs.	November 2019
Review and validate information reported to HHS by governmental entities that operate LPPFs quarterly.	January 2020 and ongoing
Develop and implement reporting portal for governmental entities that operate LPPFs.	January 2020
Complete data assessment for enhanced reporting and monitoring of additional local funding structures.	April 2020
Develop accountability monitoring plan for additional local funding structures.	August 2020

Fiscal Year 2021 Steps Taken:

Release of the Texas Monitoring Plan for Public Comment

Texas HHSC launched the LPPF reporting system and began collecting quarterly reports in 2020. After a few quarters of collecting quarterly reports, even in the midst of COVID-19, Texas focused efforts on developing the accountability monitoring plan for additional local structures. In addition, based upon lessons learned from the initial LPPF-specific quarterly reports, Texas made plans to refine the reporting required from governmental entities that operate LPPFs and to expand to other types of local fund sources in the future. The plan was posted for public comment in October and November 2020. The plan consists of 5 steps:

1. Annual survey
2. Risk assessment
3. Additional information for selected entities
4. Deep dive reviews
5. Determination

After receiving public comment, it became clear that additional resources for both staff and information technology systems would be necessary to successfully implement the plan as there are as many as 1500 identified different governmental entities that submit or certify local funds for use as non-federal share in the Medicaid program.

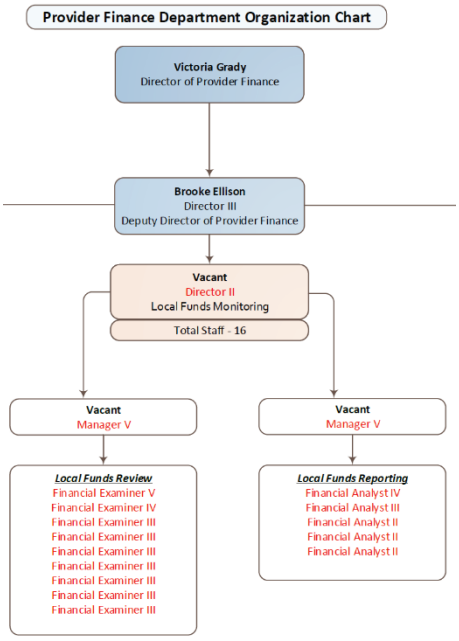
Investment in Resources Needed to Launch the Monitoring Plan

The 87th Texas Legislature met in Regular Session from January 12, 2021 through May 31, 2021. During the Regular Session, the Texas Legislature appropriated at least 14 Full Time Equivalents and capital authority for the information technology system necessary to implement the Monitoring Plan. The resources are appropriated to HHSC with an effective date of September 1, 2021.

On June 18, 2021, Senate Bill 1, 87th Texas Legislature, Regular Session, 2021, was signed into law. HHSC immediately put steps into motion to implement the creation of the resources. On August 2, 2021, the Director of Local Funds Monitoring position was posted and began accepting applications. The initial set of applications received have been reviewed and first round interviews are schedule for early September.

Fiscal Year 2022-23 Planned Steps:

Complete Staffing for All New Positions



HHSC plans to fill 17 full time equivalent positions to support the Local Funds Monitoring teams. The planned structure includes the Local Funds Review team of Financial Examiners who will be responsible for the implementation of steps 1 through 4 of the Monitoring Plan. The Local Funds Reporting team will be responsible for working HHSC legal counsel to complete step 5 of the monitoring plan. The Reporting team will also complete all federal and state reporting related to the use of local funds in the Medicaid program.

To ensure that the positions are filled timely, HHSC plans to use the dates below as goals (assuming applications are received from a sufficient pool of qualified candidates).

	Director and Managers	Financial Analyst IV and Financial Examiner V	Financial Analyst III and Financial Examiner IV	Financial Analyst II and Financial Examiner III
Positions Posted	8/2/2021	9/10/2021	10/8/2021	11/5/2021
Posting Closes	8/16/2021	9/24/2021	10/22/2021	11/19/2021
Interviews Begin	9/3/2021	10/1/2021	10/29/2021	11/26/2021
Offers Made	9/14/2021	10/12/2021	11/9/2021	12/7/2021
Potential Start Date	9/28/2021	10/26/2021	11/23/2021	12/21/2021

Finalize Monitoring Plan via Texas Rulemaking Procedures

While HHSC undertook a public comment process on the draft Monitoring Plan in October and November 2020, implementation of the plan will require the creation of formal Texas regulations via the Texas rulemaking procedures.

The proposed rules targeted date for publication is December 1, 2021. Assuming a public comment period of 30-days, as is typical, HHSC will likely need several weeks to review in January and February to examine all comments and make any necessary modifications in response to public comment.

The Final Rules will likely be published for adoption around March 31, 2022.

Attachment B – Oversight and Monitoring Plan for Local Funds Used in Medicaid in Texas

Implement Monitoring All Phases

HHSC will expand monitoring activities based upon provider type, volume of funds, and method of contribution according to the phases and targeted dates below.

Phase	Description	Target Implementation Date
1	Governmental entities operating Local Provider Participation Funds or other provider tax structures	Partially Implemented in 2020; Full Implementation on April 1, 2022
2	Governmental entities transferring non-LPPF funds to support Medicaid payment programs for hospital services	October 1, 2022
3	Governmental entities transferring non-LPPF funds to support Medicaid payment programs for non-hospital services, including nursing facility services, intermediate care facility services, and other acute or long-term care services	April 1, 2023
4	Governmental entities certifying public expenditures	October 1, 2023