

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 health safety net.

State Directed Payment Topic	Modifications/Information Required for State Fiscal Year (SFY) 2022 Under Option #2
Quality Incentive Payment Program (QIPP)	<ol style="list-style-type: none">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).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.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.

<p>Comprehensive Hospital Increase Reimbursement Program (CHIRP)</p>	<ol style="list-style-type: none"> 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. 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.
<p>Texas Incentives for Physicians and Professional Services (TIPPS)</p>	<ol style="list-style-type: none"> 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). 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. 3. 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.
<p>Rural Access to Primary and Preventative Services (RAPPS)</p>	<ol style="list-style-type: none"> 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). 2. 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.
<p>Behavioral Health Services Directed Payment Program (BHS)</p>	<ol style="list-style-type: none"> 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). 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. 3. 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

	<p>sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.</p>
<p>Sources of Non-Federal Share (IGTs, Bonds, and Debt Instruments)</p>	<p>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.</p> <ol style="list-style-type: none"> 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. 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): <ol style="list-style-type: none"> 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. 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.
<p>Sources of Non-Federal Share (Locality Taxes and LPPFs)</p>	<p>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:</p> <ol style="list-style-type: none"> 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. 2. Written attestation from the state that: <ol style="list-style-type: none"> 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.

	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.
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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.