

**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.

<b>State Directed Payment Topic</b>	<b>Modifications/Information Required for State Fiscal Year (SFY) 2022 Under Option #2</b>
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).  <b>State Response:</b> 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.

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?

	<p>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)?</p> <p>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.</p> <p>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> <p><b>State Response:</b> 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.</p> <p>a. Does CMS have specific recommendations for how to isolate the impact of DPP from other state-wide initiatives?</p>
<p>Comprehensive Hospital Increase Reimbursement Program (CHIRP)</p>	<p>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.</p> <p><b>State Response:</b></p> <p>Aggregate Payment Amounts:</p>

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.

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?

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?
- b. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable?

<p>Texas Incentives for Physicians and Professional Services (TIPPS)</p>	<p>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).</p> <p><b>State Response:</b> 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.</p> <p>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.</p> <p><b>State Response:</b> 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?</p> <p>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</p>
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selection of measures used for tracking provider quality improvement, such as the structure measures or hospital safety measures.

- a. 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?

With regard to year-over-year improvement, we also have additional questions:

- b. HHSC assumes this applies to provider-level pay-for-performance measures in addition to evaluation measurement at the Medicaid-member level. Is that correct?
- c. How should this apply to structure measures currently included in the program?
- d. 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?
- e. Would maintenance of a rate of performance for a high performer be acceptable?

- 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.

**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.

- b. 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?

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



	<p>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).</p> <p>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.</p> <ul style="list-style-type: none"> <li>c. Does CMS have a recommendation for how the state can address this issue in the evaluation plan?</li> <li>d. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable?</li> </ul>
<p>Rural Access to Primary and Preventative Services (RAPPS)</p>	<ol style="list-style-type: none"> <li>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).</li> </ol> <p><b>State Response:</b> 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.</p> <ol style="list-style-type: none"> <li>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.</li> </ol> <p><b>State Response:</b> 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</p>

	<p>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.</p> <p>c. 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?</p> <p>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).</p> <p>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.</p> <p>e. Does CMS have a recommendation for how the state can address this issue in the evaluation plan?</p> <p>f. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable?</p>
Behavioral Health Services Directed Payment Program (BHS)	<p>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).</p> <p><b>State Response:</b> 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.</p>

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.

f. 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?

With regard to year-over-year improvement

- a. HHSC assumes this applies to provider-level pay-for-performance measures in addition to evaluation measurement at the Medicaid-member level. Is that correct?
- b. How should this apply to structure measures currently included in the program?
- c. 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?
- d. Would maintenance of a rate of performance for a high performer be acceptable?

	<p>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 sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.</p> <p><b>State Response:</b> 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, 2021 call with Texas.</p> <p>d. 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?</p> <p>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).</p> <p>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.</p> <p>g. Does CMS have a recommendation for how the state can address this issue in the evaluation plan?</p> <p>h. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable?</p>
Sources of Non-Federal Share (IGTs, Bonds,	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>and Debt Instruments)</p>	<p>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.</p> <p><b>State Response:</b> Texas confirms this statement.</p> <p>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):</p> <ul style="list-style-type: none"> <li>a. The names of entities that purchase bonds (or other debt instruments) used to finance the non-federal share of Medicaid payments.</li> <li>b. Identification of any providers or provider-related organizations that are bond (or other debt instruments) purchasers.</li> <li>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.</li> <li>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.</li> </ul> <p><b>State Response:</b> 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:</p> <ul style="list-style-type: none"> <li>(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);</li> <li>(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</li> <li>(3) clarity on how frequent this reporting would be due.</li> </ul> <p>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</p>
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	<p>use to effectively oversee how these program payments are funded by the state or local units of governments.</p> <p><b>State Response:</b> S.B. 1 (Article II, Health and Human Services Commission, Rider 15), 87<sup>th</sup> 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.</p>
<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"> <li>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.</li> </ol> <p><b>State Report:</b> Please see Attachment C, which is the most recent final data we have at this time.</p> <ol style="list-style-type: none"> <li>2. Written attestation from the state that: <ol style="list-style-type: none"> <li>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).</li> <li>b. No localities impose a tax on hospitals that are not located within the boundaries of their jurisdiction.</li> <li>c. That the state will actively oversee how the locality taxes and LPPF arrangements meet federal requirements on an ongoing basis.</li> </ol> </li> </ol> <p><b>State Response:</b> 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.</p> <ol style="list-style-type: none"> <li>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.</li> </ol> <p><b>State Response:</b> 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</p>

	<p>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:</p> <p>(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?</p> <p>(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?</p>
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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.