<u>Texas & CMS Meeting: Friday, August 20, 2021</u>

<u>Discussion: State Directed Payment Preprint Modifications</u>

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.

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

<u>RAPPS, CHIRP, TIPPS, and BHS:</u>

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?

  September 15, 2021 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.

  September 15, 2021 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.

  September 15, 2021 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: **September 15, 2021 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. **September 15, 2021 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. 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? **September 15, 2021 State Response:** All payments will be reconciled to actual utilization data during the final reconciliation. 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. **September 15, 2021 State Response:** Noted. The importance of the program to our healthcare safety net is significant so HHSC will absorb the administrative burden. 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? **September 15, 2021 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. 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. **September 15, 2021 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. 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. **September 15, 2021 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. 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). **September 15, 2021 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. **September 15, 2021 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. 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. **September 15, 2021 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.
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:

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

September 15, 2021 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?

   September 15, 2021 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.

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? **September 15, 2021 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? **September 15, 2021 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. 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? **September 15, 2021 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? **September 15, 2021 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. **September 15, 2021 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? **September 15, 2021 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.

	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. **September 15, 2021 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? **September 15, 2021 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? **September 15, 2021 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. **September 15, 2021 State Response:** HHSC has completed the analysis and it can be found in the Attachment labeled "CHIRP_9.10.21_90% ACR.

	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. **September 15, 2021 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. **September 15, 2021 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? 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. **September 15, 2021 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.
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: **September 15, 2021 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. b. **September 15, 2021 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. 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? **September 15, 2021 State Response:** All payments will be reconciled to actual utilization data during the final reconciliation. 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. **September 15, 2021 State Response:** Noted. The importance of the program to our healthcare safety net is significant so HHSC will absorb the administrative burden. 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? **September 15, 2021 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. 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. **September 15, 2021 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. f. 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. **September 15, 2021 State Response:** The state does not anticipate a change in the reimbursement levels indicated in the pre-print as a result of this change. 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. 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. **September 15, 2021 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.

	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. 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? **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. **September 15, 2021 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. 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. **September 15, 2021 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. 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? **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. **September 15, 2021 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. c. 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. **September 15, 2021 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. 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.) **September 15, 2021 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. d. Would maintenance of a rate of performance for a high performer be acceptable? **<u>CMS Response:</u>** 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. **September 15, 2021 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. 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? **CMS Response**: Please refer to the overarching comments at the top of this paper. **September 15, 2021 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.

	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. **September 15, 2021 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? b. 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. **September 15, 2021 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.
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: **September 15, 2021 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 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. **September 15, 2021 State Response:** Texas confirms CMS' understanding. b. 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. **September 15, 2021 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. c. 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? **September 15, 2021 State Response:** All payments will be reconciled to actual utilization data during the final reconciliation. d. 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. **September 15, 2021 State Response:** Noted. The importance of the program to our healthcare safety net is significant so HHSC will absorb the administrative burden. e. 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? **September 15, 2021 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.

	f. 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. **September 15, 2021 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. g. 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. **September 15, 2021 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. 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. **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. 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 contractor to do so? **CMS Response:** Please refer to the overarching comments at the top of this paper. **September 15, 2021 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. c. 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. **September 15, 2021 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? d. 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. **September 15, 2021 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: **September 15, 2021 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 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.

	September 15, 2021 State Response: Texas confirms CMS' understanding. b. 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. **September 15, 2021 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. c. 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?

	September 15, 2021 State Response: All payments will be reconciled to actual utilization data during the final reconciliation. d. 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. **September 15, 2021 State Response:** Noted. The importance of the program to our healthcare safety net is significant so HHSC will absorb the administrative burden. e. 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? **September 15, 2021 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. f. 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. **September 15, 2021 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. g. 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? **September 15, 2021 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. 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.

	a. 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? **September 15, 2021 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. **September 15, 2021 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 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? **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. **September 15, 2021 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. b. 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. **September 15, 2021 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. 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? **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. **September 15, 2021 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. d. 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. **September 15, 2021 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. 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. **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. 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 contractor to do so? **CMS Response:** Please refer to the overarching comments at the top of this paper. **September 15, 2021 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. b. 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. **September 15, 2021 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? c. 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. **September 15, 2021 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.
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. **September 15, 2021 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	

September 15, 2021 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.

	September 15, 2021 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. **September 15, 2021 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. **September 15, 2021 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. **September 15, 2021 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. **September 15, 2021 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. <u>HHSC believes strongly that this is clear evidence that no hold harmless arrangement exists between the local government or the state for those providers.</u> A copy of the analysis described above can be found in Attachment B.

	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. **September 15, 2021 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.

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.