TX_ Fee_AMC.PC.SP_Renewal_20220901-20230831 (TIPPS)
Round 1 Question Set
April 6, 2022

SECTION I: DATE AND TIMING INFORMATION

1. CMS would like to note that prior approval for payment arrangements under 42 C.F.R. § 438.6(c) are for a specific time period and cannot be automatically renewed. Specifically, 42 C.F.R. 438.6(c)(3)(ii) defines approval for any fee schedules (minimum fee schedules, maximum fee schedules and/or uniform increases) for one rating period. If the state intends to continue this payment arrangement in future years, it would need to obtain approval for this payment arrangement for each successive year. Please acknowledge this policy.

   State Response (April 21, 2022): The state acknowledges the need to obtain approval for this payment arrangement for each successive year.

2. Preprint Question 4:
   a. Can the state please confirm if the amount provided in response to question 4 includes provisions for non-benefit costs such as margin, administrative load, and/or taxes and fees? If so, we would appreciate if the state could provide the amounts attributed to these non-benefit cost provisions.

      State Response (April 21, 2022): The amount provided does include the estimated amounts for risk margin, administration, and taxes.

   b. The total dollar amount estimate provided for SFY 2023 is $635 million, while the total dollar amount estimate for SFY 2022 was $600 million. Is the increase attributed to the state adding OBGYN clinics for class 3 participation? Or are there other factors associated with the increase?

      State Response (April 21, 2022): To estimate the SFY23 estimated dollar amount, the state trended forward the SFY22 all-funds amount to account for anticipated caseload growth. HHSC will submit a revision to the pre-print and provide final component and non-benefit cost provision amounts when available.

   c. Please provide estimates of the share of the total dollars provided in response to question 4 that is for:
      i. Component 1 - $387,985,000 (65%)
      ii. Component 2 - $149,225,000 (25%)
      iii. Component 3 - $59,690,000 (10%)
      iv. Administration, profit margin, or premium tax. - 38,100,000

SECTION II: TYPE OF STATE DIRECTED PAYMENT

3. Preprint Question 8 and Attachment B:
   a. Please affirm that the payments required under this payment arrangement will only be made for Medicaid services on behalf of Medicaid beneficiaries covered under the Medicaid managed care contract for the SFY 2023 rating period only and that the payments will not be made on behalf of individuals who are uninsured, covered for such

services by another insurer (e.g. Medicare), nor Medicaid services provided through the state fee-for-service program.

State Response (April 21, 2022): The state affirms that the payments required under this payment arrangement will **only** be made for Medicaid services on behalf of Medicaid beneficiaries covered under the Medicaid managed care contract for the SFY 2023 rating period **only** and that the payments will not be made on behalf of individuals who are uninsured, covered for such services by another insurer (e.g. Medicare), nor Medicaid services provided through the state fee-for-service program.

b. As noted in the approval letter for the SFY 2022 TIPPS proposal, for the SFY 2023 rating period, payments for all components of the arrangement will need to be conditioned upon the delivery and utilization of covered services rendered to Medicaid beneficiaries during the SFY 2023 rating period. This means that for any part of the payment arrangement that bases payment on services rendered during a previous rating period, the requirement of a reconciliation threshold higher than zero percent will not be considered sufficient to meet this regulatory requirement.

   i. Please provide a confirmation that no reconciliation threshold will be higher than zero percent for any TIPPS components for SFY2023.

   State Response (April 21, 2022): The state confirms the reconciliation threshold will be zero percent for any TIPPS components for SFY2023.

   ii. For the SFY 2022 preprint review, the state provided an attachment (Att B1) that detailed the reconciliation process. Please provide documentation that provides clarity on the reconciliation process.

   State Response (April 21, 2022): HHSC, 120 days after the last day of the program period, will reconcile the interim allocation of funds across enrolled providers to the actual Medicaid utilization across these providers during the program period as captured by Medicaid MCOs contracted with HHSC for managed care. Please see the attached file detailing the reconciliation process for SFY 2023.

   iii. Please provide an explanation of what amount will be targeted for the reconciliation (for example will it be based on actual utilization, or will it be based on 65 and 25 percent, respectively, of total TIPPS funding that is based on actual utilization)?

   State Response (April 21, 2022): The reconciliation for the TIPPS program will be based on actual utilization and an independent reconciliation will be completed for Component 1 and 2.

iv. The state indicated the following during the SFY 2022 review of TIPPS. Has any of this changed for SFY 2023 TIPPS payments?

A. The state's intent is that there will be no changes to the payments that the MCO receives from the state; payment changes would occur only for the providers.

B. The state will inform the MCOs via a payment scorecard that will show any provider level payment adjustments that are required.

State Response (April 21, 2022): With respect to the first above statement, once HHSC completes the reconciliation of Components 1 and 2, the state's actuary will review the results and determine if TIPPS capitation rate changes are necessary to adhere to actuarial soundness requirements. The state affirms the second above statement for TIPPS.

SECTION IIB: State Directed Fee Schedules:

4. Preprint Question 19 and Attachment C:

a. For SFY 2023, what changes, if any, has the state made to the payment methodology for this payment arrangement?

State Response (April 21, 2022): The state has not made any changes to the payment methodology for this payment arrangement.

b. We note the following changes for uniform increases, can the state please confirm this is correct and provide a brief explanation as to the why the changes.

	SFY 2022	SFY 2023
Component 1 (uniform dollar increase)	Per member per month rates: $47.99 for class 1 and $29.15 for class 2.	Per member per month rates: $49.91 for class 1 and $30.31 for class 2.
Component 2 (uniform percent increase)	62.68% for class 1 and 26.87% for class 2	62.6% for class 1 and 26.8% for class 2
Component 3 (uniform percent increase)	58.64%	56.57%

State Response (April 21, 2022): To estimate the SFY23 estimated dollar amount, the state added data related to the updated taxonomy codes for eligible providers, then trended forward the SFY22 all-funds amount, to account for anticipated caseload growth, resulting in changes to the uniform increases. HHSC will submit a revision to the pre-print and provide final component and non-benefit cost provision amounts when available.

c. We understand from the SFY 2022 TIPPS review that the uniform dollar and percent increases in Components 1 and 2 may fluctuate based on the reconciliation to actual utilization that will be conducted upon the conclusion of the rating period.

i. Is this still the case for SFY 2023? If so, please add this detail to Attachment C.
State Response (April 21, 2022): Yes, uniform dollar and percent increases in Components 1 and 2 may fluctuate based on the reconciliation to actual utilization that will be conducted upon the conclusion of the rating period. We will add the specific increases to Attachment C for SFY2023 when available.

ii. Is it also correct that the uniform percent increases for Component 3 will not change?
State Response (April 21, 2022): Correct, the uniform percent increases for Component 3 will not change.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

5. Preprint Question 20b.:
   a. We understand that OB-GYNs have been added to Component 3 for SFY 2023 but this is not reflected in Attachment D. Can the state please address?

      State Response (April 21, 2022): While the Component 3 taxonomy list has expanded to include 9 additional taxonomy codes applicable to OB-GYNs providers, an OB-GYN provider participating only in Component 3 (determined to be ineligible for Class 1 or 2 participation) will still remain classified as a Class 3 provider. No changes are required to Attachment D because there have been no changes to the actual provider types eligible for Class 3 participation, although additional taxonomy codes may allow certain providers to qualify that did not for SFY2022. The list of taxonomy codes for eligible providers has been expanded with codes applicable to OB-GYN providers.

   b. Can the state please confirm that with the addition of OB-GYNs, there is no overlap between the provider classes?

   c. **State Response (April 21, 2022):** HHSC will adjudicate each billing NPI submitted on the applications for participation in Component 1, 2, and/or 3 based on applicable provider class. While the state has expanded the list of eligible Component 3 taxonomy codes to allow for expanded OB-GYN participation as Class 3 providers, the component eligibility requirements have not changed and there will be no overlap between provider classes.

   d. What is the timing for providers to submit enrollment applications to the state for the SFY 2023 rating period?

      State Response (April 21, 2022): Enrollment applications for the SFY23 rating period were due to the state by 11:59 PM on March 29th, 2022. No applications were accepted for TIPPS SFY 23 participation after this date.

6. Preprint Question 23: Thank you for completing Table 2. We have compared the total payment level after accounting for all SDPs and PTPs from SFY 2022 to SFY 2023 (see table below). Can

the state please explain what factors contribute to the changes in total payment level from year 1 to year 2?

	SFY 2022 Total Payment Level Estimate (as a % of ACR)	SFY 2023 Total Payment Level Estimate (as a % of ACR)
Health-Related Institutions (HRI) Physician Group	100%	81%
IME Physician Group	84%	84%
Other Physician Group	60%	48%

State Response (April 21, 2022): To estimate the SFY23 total payment level, the state trended forward the SFY22 all-funds amount to account for anticipated caseload growth. Following the conclusion of the enrollment period, HHSC will submit a revision to the pre-print and provide final component and non-benefit cost provision amounts. Processing of enrollment is estimated to be completed in late April 2022.

7. Preprint Question 28: Thank you for noting that the TIPPS methodology for year 2 is assumed to be similar to year 1. Can the state please tell us when it expects provider enrollment to be completed for SFY 2023 and correspondingly, when the state will be able to provide CMS the updated actuarial certification for year 2/SFY 2023?

   State Response (April 21, 2022): Processing of enrollment is estimated to be completed in late April 2022. The state estimates the updated actuarial certification for year 2 will be available in late May to early June.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

8. Will the state include TIPPS in the capitation rates in a manner consistent with prior years? If not, please describe the differences in the methodology this year.
   State Response (April 21, 2022): Yes.

9. As part of the SFY 2022 preprint review, the state indicated that it did not anticipate any amendments to the rates or rate certifications to account for the reconciliation requirement.
   a. Is this still the case for SFY 2022?

      State Response (April 21, 2022): If necessary, the rates and rate certifications will be amended.
   b. And does the state expect to amend the rates or rate certifications as a result of the reconciliation for SFY 2023?

      State Response (April 21, 2022): If necessary, the rates and rate certifications will be amended.

10. Does the state direct the plans to set aside any portion of the capitation rate paid to them for this payment arrangement?

    State Response (April 21, 2022): MCOs retain 2.5% for administration, 1.5% for STAR risk margin, 1.75% for STAR+PLUS and STAR Kids risk margin, and 1.75% for premium taxes.

11. Are the plans directed to use a specific portion of the capitation rates paid to them to pay out Component 1?
    State Response (April 21, 2022): Scorecards direct the MCOs to pay out the capitation received for components 1 and 2, after accounting for MCO fees detailed in question 10.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

Summary: The financing of the state directed payment paid to physician and practitioners under the TIPPS program appear to be financed by local units of government providing intergovernmental transfers (IGTs), funds for which are largely derived from the taxing authority of these units of government through the Local Provider Participation Fund, or LPPF. For the most part, the state said that the majority of the funding would come from state teaching hospitals and academic medical centers that receive appropriations from the state. However, anything not funded by these teaching hospitals would be funded by units of local government, via the LPPFs. The state is attesting that the LPPF is broad-based and uniform. However, it appears that not all hospitals are being taxed under the LPPF, and it also appears that some of the units of government providing IGTs do not receive any state appropriated funds and do not have any taxing authority. The state has indicated that these units of government will be funding these through public private partnerships.

12. For any entities that may or may not have taxing authorities and do not receive any state appropriated funds, such as Texas Tech University Health Sciences Center AMA, please describe how the funding for those IGTs is derived. We note that in some of the funding information provided under the various proposals, that some of the entities which do not have taxing authority and do not receive payments are funding a substantial IGT. The state has an obligation, regardless of the IGT being voluntary or compulsory, to ensure that all federal requirements related to program financing are met.

    State Response (April 21, 2022): The state affirms understanding of this requirement. The Provider Finance Department within HHSC has established a Local Funds Monitoring team that is responsible for collecting information from each entity that provides local funds as the non-federal share of Medicaid payments. This oversight mechanism is a combination of self-reported quarterly data, review of public record data, and analysis of each funding source and related documentation. All local funds are being phased into this oversight process, as described in the proposed rule available here. The state understands and agrees that it is our responsibility to ensure that funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51. The funds transferred to the state are public funds and come from various eligible sources based on the local governmental entity's available funds, such as general appropriations, county or city appropriations, commercial patient revenue where the entity is a service provider, or other available public funds.

Texas Tech, like most state institutions of higher education, receives funds directly through general appropriation and has access to other sources of funds that are public and eligible for use as the non-federal share.

13. Please affirm that no payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

    State Response (April 21, 2022): The state affirms that no payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

14. Please confirm that the list of IGT Entities are consistent from the original submission to this renewal. Have providers been added or renewed? And please provide any IGT agreements or Memorandums of Understanding (MOU) with this renewal submission.

    State Response (April 21, 2022): At the original time of preprint submission, HHSC has not sent suggested IGT amounts to IGT entities. An updated list of IGT entities will be provided at a later date. There is no compulsory IGT requirement and there are no agreements requiring an IGT of any amount from a state or local governmental entity. Due to the voluntary nature of the IGT contribution, local governmental entities complete a Declaration of Intent form notifying HHSC of the funds that are intended to be transferred via IGT.

15. How were the IGTs arranged? Are all of the IGT Entities the state listed in all Renewals signing an IGT Agreement, or did the Texas Legislature earmark those entity's funds for being transferred to the SMA?

    State Response (April 21, 2022): There is no compulsory IGT requirement and there are no agreements requiring an IGT of any amount from a state or local governmental entity. Due to the voluntary nature of the IGT contribution, local governmental entities complete a Declaration of Intent form notifying HHSC of the funds that are intended to be transferred. In limited circumstances, the Texas Legislature appropriates specific public funds to a governmental entity with direction to use such funds in support of the Medicaid program.

16. 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 (April 21, 2022): The Provider Finance Department within HHSC has established a Local Funds Monitoring team that is responsible for collecting information from each entity that provides local funds as the non-federal share of Medicaid payments. This oversight mechanism is a combination of self-reported quarterly data, review of public record data, and analysis of each funding source and related documentation. All local funds are being phased into this oversight process, as described in the proposed rule available here.

17. During the 2021 preprint reviews, it was noted that the state had proposed to use bonds or other such debt instruments to assist in funding the non-federal share of the Medicaid payments proposed in some of the pre-prints. Does that continue to be the case in these pre-print proposals or has the state changed the manner in which the payments proposed in 2022 are funded?

    State Response (April 21, 2022): To the extent that a governmental entity uses bonds or other debt instruments, the oversight provided by the Local Funds Monitoring team will ensure that such instruments are not derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share and that the governmental entity is not improperly utilizing federal funding as the source of the IGT used to fund the non-federal share. HHSC continues to monitor local funds, to ensure the permissibility of local funds. The state understands and agrees that it is our responsibility to ensure that funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51.

18. In "Attachment F – IGT Entities" " - 5 entities are classified as "other" under operational nature. Please define the operational nature for each of these entities as most are not classified as typical IGT-eligible entities (I.e. state, county, city).

    State Response (April 21, 2022): HHSC has provided a list for Attachment F – IGT Entities that makes designations of the local governmental entities that provide IGT of public funds for use as the non-federal share consistent across programs. Only units of state or local government are permitted to submit IGT for use as the non-federal share of Medicaid payments. Texas has several classes of local entities that are referred to as Hospital Authorities, Hospital Districts, Local Mental Health Authorities, and others that are generally contiguous with a specific county or city, but are a unique unit of local government; therefore, the county or city designation was not appropriate. Due to the limitation to County, City, or Other, we selected "Other" for these various entity types. These entities have been in place for many decades and, much like a county or city, are units of local government with varying sources of public funds, including taxing authority, state appropriation, county appropriation, etc. depending on their individual enabling statutes.

19. CMS continues to harbor serious concerns regarding the financing for the CHIRP, RAPPS, and TIPPS program that are financed by Local Provider Participation Fund health care-related taxes. Specifically, CMS is concerned that this method of financing contains a hold harmless arrangement as laid out at section 1903 (w)(4)(C) of the Act and implementing regulations at 42 CFR § 433.68 (f)(3). CMS has a non-discretionary obligation to reduce the state's medical assistance expenditures by the amount of any health-care related taxes if such health care-related taxes have in effect a hold harmless arrangement. CMS has indicated that Texas could resolve those concerns either by providing the information requested by CMS to show that no such hold harmless arrangements exist or by showing Texas must show that it is acting to end any such

arrangements that are in place, including by issuing guidance to its providers that such practices constitute impermissible hold harmless arrangements. Can the state please confirm that its position on this issue has not changed?

State Response (April 21, 2022): The state understands and agrees that it is our responsibility to ensure that funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51. The state continues to affirm that no such hold harmless arrangement exist, as the local governmental entities that implement a Local Provider Participation Fund, do so in accordance with §1903(w)(4) of the Social Security Act and federal regulations found at 42 CFR §433.68(f). The Local Funds Monitoring team was established to ensure all local funds are derived from permissible sources, including confirming that funds derived from a Local Provider Participation Fund are consistent with a permissible health care related tax in that it is imposed in a broad based and uniform manner, and that the local governmental entity imposing the tax does not hold any facility harmless from such tax.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

20. Thank you for providing a Year 2 Evaluation Plan for CHIRP, BHS, TIPPS and RAPPS. We understand from the Evaluation Plan that only BHS baseline data was available at the time of the SFY 2023 preprint submission. Our understanding from prior conversations with the state in November 2021 was that provider-reported data covering January-June 2021 would be available in February 2022 and full CY 2021 data would be available in May 2022.
    a. Can the state please provide an update as to when preliminary data from Jan-June 2021 will be available for CHIRP, RAPPS and TIPPS?

       State Response (April 21, 2022): Rather than submitting the preliminary 6-month data from January to June of 2021, CHIRP, RAPPS and TIPPS providers will be submitting full CY 2021 data to HHSC by the end of May 2022.

    b. And will full CY 2021 data still be available in May 2022?

       State Response (April 21, 2022): Full CY 2021 data will be reported by DPP BHS providers in April of 2022, and full CY 2021 data will be reported by CHIRP, TIPPS and RAPPS providers by the end of May 2022. HHSC plans to review the provider-reported data from June to August of 2022. The final Year 1 Evaluation Report will be submitted to CMS no later than February 2023.

    c. We also understood from our November 2021 discussion that for state-level measures using EQRO data covering CY 2021, preliminary data would be ready in August 2022 and final data in October 2022. Is this still the case?

       State Response (April 21, 2022): Yes, this is still the case. HHSC is set to receive preliminary data from the EQRO in August 2022 and final data from the EQRO in

October 2022. As included in the response above, the final Year 1 Evaluation Report will be published no later than February 2023.

21. Thank you for providing preliminary evaluation performance targets for the BHS program-specific evaluation measures. The evaluation plan indicates that "After the baseline data for all four DPPs, pending CMS approval, are known for the full 12 months of CY 2021, HHSC will establish final evaluation performance targets." We previously understood that the state would be submitting an addendum to CMS to update the improvement targets once the CY 2021 data is available in summer/fall 2022. Can the state please provide an update on this effort?

    State Response (April 21, 2022): Once the baseline data for all four DPPs are evaluated for the full 12-months of CY 2021, HHSC will establish final evaluation performance targets for all DPPs. As included in the responses above, HHSC plans to review the provider-reported data for all DPPs from June to August of 2022, and HHSC is set to receive final data from the EQRO in October 2022. Based on these dates, HHSC will establish evaluation performance targets for all DPPs no later than February 2023 by including them in the final Year 1 Evaluation Report instead of an addendum.