

SECTION I: DATE AND TIMING INFORMATION

1. Could 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.

2. Preprint Question 4:

- a. Please provide estimates of the share of the total dollars provided in response to question 4 that is for:
 - i. Component 1 - \$108,033,858.05
 - ii. Component 2 - \$58,172,077.41
 - iii. Administration, profit margin, or premium tax. - \$16,620,593.55
- b. The SFY2022 preprint's estimated total dollar amount was \$173,469,308 and the SFY2023 estimated dollar amount is \$182,826,529, which is a \$9,357,221 increase. Can the state explain the reason for the increase?

State Response (April 21, 2022): To estimate the SFY2023 estimated dollar amount, the state trended forward the SFY2022 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.

CMS Response (5/11/22): When does the state anticipate being able to provide the final component and non-benefit cost provision amounts to CMS?

State Round 2 Response (May 16, 2022): HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. HHSC will provide the final documents to CMS as soon as they are available. However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS' review. HHSC anticipates being able to provide the updated preliminary models to CMS no later than May 23, 2022.

CMS Response 6/3/22: The revised preprint updates the total dollar estimate to be \$214,991,787 for SFY 2023.

- i. For the SFY 2022 rating period, the state provided a total dollar estimate of \$176,400,019 for the BHS state directed payment. Based on available data to-date, can the state provide a revised accounting of what the actual spend has been to date for RAPPs for SFY 2022?
- ii. Can the state please discuss what contributed to the increase in the total dollar estimate from SFY 2022 to SFY 2023?
- iii. Does the state anticipate this total dollar amount changing with the final submission?

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State Round 3 Response (June 8, 2022):

1.-As of May 31, 2022, total payments for the SFY2022 DPP-BHS directed payment program are approximately \$142 million, with payments beginning in January 2022 after the pre-print was approved; these payments are for 9 months of the program year. Based on the total expenditures, the estimated annualized total expenditure for SFY2022 will be \$190 million. The estimated annualized total expenditure is subject to change.

2.- The increase in the total dollar estimate from SFY 2022 to SFY 2023 is due to an increase supported by actuarial trend factors.

3.-The state anticipates an increase to the total dollar amount for SFY 2023 in the final submission to CMS.

3. Preprint Question 6: The state notes that there is a provider type change with this SFY 2023 submission. We understand that this state directed payment will now include Local Behavioral Health Authorities. Is that the extent of this change?

State Response (April 21, 2022): Yes, the extent of the change from SFY2022 to SFY2023 was the addition of Local Behavioral Health Authorities (LBHAs) as an eligible provider type.

4. We would appreciate if the state could confirm that the correct SFYs are referenced in Attachments B, C and E. If not, it would be helpful for the state to update the attachments.

State Response (April 21, 2022): Following the conclusion of the enrollment period, HHSC will submit a revision to referenced attachments with the updates SFYs. **Updated State Response during Round 2 (May 16, 2022):** However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS' review. HHSC anticipates being able to provide the updated preliminary models to CMS no later than May 23, 2022.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

5. Preprint Question 8:

- a. In Attachment B:

- i. Please provide if there are any changes to the ways the payments will be made for Component 1 and Component 2 for SFY 2023.

State Response (April 21, 2022): There will be no changes to the ways the payments will be made for Component 1 and Component 2 for SFY2023.

- ii. The state says:

- A. "Component 1 is a uniform dollar increase based on SFY19 (September 2018 – August 2019) units and will be paid prospectively on a monthly basis (equal to 1/12 of the annual amount) based on the historical utilization of the 20 most utilized CMHC and LBHA procedure codes from SFY19, increased by 7% to account for projected SFY19 to SFY22 enrollment growth among the three (3) Medicaid managed care programs (STAR, STAR+PLUS, and STAR Kids)." This is the same

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methodology that was provided for SFY 2022. Does this need to be updated for SFY 2023?

State Response (April 21, 2022): The methodology for SFY 2023 does not need to be updated. No changes were made to the methodology that was provided for SFY2022.

CMS Response (5/11/22): The above description should reflect SFY 23, not SFY 22, when it says “increased by 7% to account for projected SFY19 to SFY 22 enrollment growth”, correct?

State Round 2 Response (May 16, 2022): The above description was correct at the time of pre-print submission. SFY23 trend factors will be updated when HHSC submits the revised pre-prints. However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS’ review. HHSC anticipates being able to provide the updated preliminary models to CMS no later than May 23, 2022.

- B. “An annual reconciliation will be performed to align payments with the actual SFY22 utilization.” Please clarify and rectify if needed if this should say “SFY 2023 utilization”.

State Response (April 21, 2022): Calculation has not yet begun for SFY2023, but an updated Attachment B will be submitted when complete to reference SFY2023 utilization. **Updated State Response during Round 2 (May 16, 2022):** HHSC will provide an updated Attachment B on 5/23 with updated model information.

CMS Response 6/3/22: Can the state please clarify what changed in the updated reconciliation process document?

State Round 3 Response (June 8, 2022): Other than updated dates to reflect the appropriate program year, there were no changes in the updated reconciliation process or Attachment B.

- b. As noted in the approval letter for the SFY 2022 BHS 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 BHS components for SFY2023.

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

CMS Response (5/11/22): According to the file containing the reconciliation process for SFY 2023, it appears that the reconciliation will be finalized in January 2024. Is that correct?

State Round 2 Response (May 16, 2022): The state affirms the above deadline is correct.

- iii. Please provide an explanation of what amount will be targeted for the reconciliation.

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

CMS Response 6/3/22:

1. Our understanding is that the reconciliation is only applicable to Component 1, and not Component 1 and 2. Please clarify.
2. Further, during the SFY 2022 BHS preprint review, we understood that the reconciliation performed at the end of the program year will be performed to reconcile to the actual value of Component 1 based upon the actual value of the overall program as paid through the program year. If the actual program size fluctuates as a result of caseload, the size of Component 1 would fluctuate proportionately as Component 1 is designed to be equal to a percentage of the overall program value. Does that state plan to use this reconciliation methodology for BHS Component 1 for SFY 2023?

State Round 3 Response (June 8, 2022):

1. An annual reconciliation will be performed only for Component 1.
2. Yes, that is correct. The reconciliation will be performed within 120 days of the end of the program year to reconcile the amount paid throughout the program year based on historical data to the actual utilization and value of the overall program within that year.

- iv. The state indicated the following during the SFY 2022 review of BHSS. 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 statement above, once HHSC completes the reconciliation of Component 1, the state's actuary will review the results and determine if BHS capitation rate changes are necessary to adhere to actuarial soundness requirements. The state affirms the second above statement for BHS and assumes that the question is meant to reference BHS, not TIPPS.
- c. For Component 1, 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.

SUBSECTION IIA: STATE DIRECTED FEE SCHEDULES

6. Preprint Question 19b (Attachment C): The state provides the same uniform dollar and percent increases that were provided in the SFY 2022 preprint review. When will the state know if these increase amounts will need to be revised?
State Response (April 21, 2022): The state will submit revised amounts for SFY2023 upon public release of the estimated payments and IGT amounts. The state estimates that a preliminary calculation will be made available by the end of April.

CMS Response (5/11/22): Can the state please provide an update as to when CMS will receive this information?

State Round 2 Response (May 16, 2022): HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. HHSC will provide the final documents to CMS as soon as they are available. However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS' review. HHSC anticipates being able to provide the updated preliminary models to CMS no later than May 23, 2022.

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CMS Response 6/3/22: We note the following changes for the uniform increases, can the state please confirm this is correct and provide a brief explanation as to what factors contributed to the changes.

	SFY 2022	SFY 2023
Component 1 (uniform dollar increase)	\$23.77 per unit	\$24.49 per unit
Component 2 for CMHCs and LBHAs that are not CCBHC certified (uniform percent increase)	52.7% per claim	47.22% per claim
Component 2 for CMHCs and LBHAs that are CCBHC certified (uniform percent increase)	57.7% per claim	52.22% per claim

State Round 3 Response (June 8, 2022):

1. The state anticipates updating the SFY 2023 uniform dollar increase and uniform percent increase. The variance in the SFY 2022 and SFY 2023 amounts is due to a number of factors, with caseload growth as the main driver specific to DPP BHS. Other factors include changes in the applicant pool with the addition of LBHAs in SFY2023 and in network status changes, as those all play a role when the growth factors are applied to calculate the total size of the program and associated components.

CMS Response (5/11/22): Please clarify what the state means by \$23.77 per unit for Component 1; will each eligible provider receive a \$23.77 payment for each service billed as listed in Attachment D or does per unit mean something else? Please update the preprint accordingly.

State Round 2 Response (May 16, 2022): For Component 1, each eligible provider will receive a uniform dollar increase for the top 20 procedure codes identified for the claims data period. Please note that the per unit increase amounts will be updated for FY23 once enrollment and calculations are complete. However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS’ review. HHSC anticipates being able to provide the updated preliminary models to CMS no later than May 23, 2022.

CMS Response (5/11/22): Please clarify what the state means by 52.7% per claim/ 57.7% per claim for Component 2; will each eligible provider receive a 52.7% or 57.7% increase for each service billed as listed in Attachment D or does per claim mean something else? Please update the preprint accordingly.

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State Round 2 Response (May 16, 2022): For Component 2, each eligible provider will receive a uniform percent increase (the higher percent increase for CCBHC certified providers) for the top 20 procedure codes identified for the claims data period. CCBHCs receive a higher percentage increase compared to non-CCBHCs because the CCBHC model has additional costs related to providing whole person care. HHSC will update the preprint accordingly. HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. HHSC will provide the final documents to CMS as soon as they are available. However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS' review. HHSC anticipates being able to provide the updated preliminary models to CMS no later than May 23, 2022.

CMS Response 6/3/22: While the state intends to maintain Component 2 as a uniform percent increase (i.e., fee schedule arrangement) for SFY 2023, can the state discuss if it plans to transition Component 2 into a performance-based payment arrangement for SFY 2024?

State Round 3 Response (June 8, 2022): HHSC staff are assessing the potential for inclusion of value-based arrangement for SFY2024 but do not have an answer to the question about the SFY 2024 plans at this time.

CMS Response (5/11/22): Please clarify – given the overlap in codes, is the 57.7% / 52.7% increase applied to payments including those under Component 1 or applied to payments absent Component 1 payments? Please update the preprint accordingly.

State Round 2 Response (May 16, 2022): The Component 1 Uniform Dollar Increase is applied to units for the specified procedure codes uniformly for CCBHCs and non-CCBHCs. The Component 2 uniform percent increase is applied to the Medicaid payments for the specified procedure codes. However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS' review. HHSC anticipates being able to provide the updated preliminary models to CMS no later than May 23, 2022. HHSC will update the preprint accordingly with the model updates on 5/23.

CMS Response 6/3/22: As discussed on our May 23, 2022 call, there is overlap in codes between Components 1 and 2. However, a distinction is that the Component 1 is a uniform dollar increase based on SFY 2019 utilization and paid out as a monthly payment that is a separate payment outside of the negotiated rate between the plans and providers. Whereas Component 2 is a uniform percent increase applied to the negotiated rate between the plans and providers at the time of claims processing. Is this an accurate summation?

State Round 3 Response (June 8, 2022):

HHSC can confirm the following: Component 1 is a uniform dollar increase based on utilization for the 3/1/19 – 2/29/20 claims data period and paid out as a monthly payment separate from the negotiated rate paid for individual services between the Managed Care plans and providers.

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Component 2 is a uniform percent increase applied to the negotiated rate between the Managed Care plans and providers at the time of claims processing for applicable services.

7. Preprint Question 19c (Attachment C):

- a. For Component 1, the state says, "Payments will be based on SFY20 (September 2019 – August 2020)". This contradicts with what the state says in preprint question 8. Please clarify.

State Response (April 21, 2022): The State will correct the pre-print to state that payments will be based on utilization within the 3/2/2019 to 2/28/20 claims data period.

CMS Response 6/3/22: The response to preprint question 8 reads, "Component 1 is a uniform dollar increase based on adjusted SFY20 (March 1, 2019 – February 29, 2020)". Can the state please clarify which dates are correct (3/1/19 -2/29/20 or 3/2/19 to 2/28/20)?

State Round 3 Response (June 8, 2022):

Component 1 is a uniform dollar increase based on utilization for the 3/1/19 – 2/29/20 claims data period.

- b. For Component 1, the state says that up to \$118.8 million will be allocated to Component 1, but then later in the response says that there will be \$107.6 million available funds available. Please clarify.

State Response (April 21, 2022): Following the conclusion of the enrollment period, HHSC will submit a revision to the pre-print and provide component estimates based on the actual, enrolled providers, indicated by NPI.

CMS Response (5/11/22): When will this information be provided to CMS?

State Round 2 Response (May 16, 2022): HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. HHSC will provide the final documents to CMS as soon as they are available. However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS' review. HHSC anticipates being able to provide the updated preliminary models to CMS no later than May 23, 2022.

- c. For Component 2, there was \$59 million allocated for this component in SFY 2022 and the SFY 2023 submission indicates \$64 million. What factors contributed to the increase?

State Response (April 21, 2022): To estimate the SFY2023 estimated dollar amount, the state trended the SFY2022 all-funds amount to account for anticipated caseload growth and the addition of LBHAs as eligible providers, resulting in changes to the uniform

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increases. 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.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

8. Preprint Question 20b:

- a. We understood from SFY 2022 that there are 39 CMHCs total in the state. Of the 39, 32 have been certified by the state as CCBHCs and the remaining seven were in the process of getting their certification by December 2021. Are there any updates on the total number of certified centers?

State Response (April 21, 2022): As of March 2022, all 39 CMHCs have received certification as a Community Certified Behavioral Health Center (CCBHC).

- b. Can the state please describe the new provider type – Local Behavioral Health Authorities – and how they relate to CMHCs? How many LBHAs does the state expect to enroll is this payment arrangement?

State Response (April 21, 2022): A Local Behavioral Health Authority (LBHA) provides comparative services as Community Mental Health Centers with a different provider classification. The state expects to enroll 1 provider that is classified as an LBHA in SFY 2023.

CMS Response (5/11/22): CMS' understanding is that there will be 39 CMHCs and 1 LBHA that will qualify for payments under Component 1 and the higher 57.7% increase under Component 2. Is this correct? Will there be any providers that qualify for lower 52.7% increase under Component 2?

State Round 2 Response (May 16, 2022): No, all of the entities expected to participate in SFY 23 (Year 2) of the DPP BHS reported that they will maintain their CCBHC certification by 9/1/2022 and therefore qualify for the higher increase.

9. Preprint Question 21: Can the state please clarify if the providers eligible for the BHS state directed payment will continue to complete an enrollment application as was done in SFY22? When will enrollment be completed?

State Response (April 21, 2022): Enrollment applications for the SFY2023 rating period were due to the state by 11:59 PM on March 29th, 2022. No applications were accepted for DPP BHS SFY 2023 participation after this date.

CMS Response (5/11/22): Can the state provide an update on the number of enrollment applications received?

State Round 2 Response (May 16, 2022): For SFY 23 (Year 2), HHSC received 50 DPP BHS applications.

CMS Response 6/3/22:

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1. Can the state explain why there are 50 BHS applications when we understand there will be 39 CMHCs and 1 LBHA participating in BHS for SFY 2023?
2. Thank you for providing the "BHS PGY1 and PGY2 Application Data Comparison by Provider Name and NPI" spreadsheet.
 - a. In looking at the SFY 22 column, it looks like there were 49 NPIs for SFY 2022. Is that correct?
 - b. In looking at the SFY 23 column, it looks like there were 264 NPIs for SFY 2023. Is that correct?
3. Can the state please discuss what factors it believes contributed to the increase in providers/NPIs for SFY 2023?
4. Are the number of applicants subject to change or is this the final count?

State Round 3 Response (June 8, 2022):

1. HHSC received a total of 50 applications for DPP BHS SFY23. Of the 50 applications received, 2 applications were submitted by entities that are not classified as a CMHC or LBHA and are not eligible for participation in the DPP BHS. An additional 8 applications were duplicates or resubmissions. Removing the ineligible applications and the duplicates/resubmissions resulted in 40 applications for 39 CMHCs and 1 LBHA.

2. a. Yes, there were 49 NPIs.

b. Yes, there were 264 NPIs.

3. In SFY2022, some providers were not aware that they needed to submit each NPI that they would like to be considered for participation in DPP BHS. In SFY 2023, many providers submitted all applicable NPIs to ensure that no NPIs that were eligible were excluded from their application.

4. This is the final count of applications, and HHSC is no longer accepting applications for DPP BHS SFY2023.

10. Preprint Question 23: CMS requests the state to provide the reimbursement rate analysis for CMHCs and LBHAs without certification in Table 2. It currently states 0% for all columns.

State Response (April 21, 2022): The state does not anticipate enrolling any providers in SFY2023 that are not certified as a CCBHC. All CMHCs currently operating in Texas eligible for the program are enrolled in the program.

CMS Response (5/11/22): In preprint question 20b, the state indicates, "there will be 2 classes of providers in this program: 1) CMHCs and LBHAs with CCBHC certification and 2) CMHCs and LBHAs without CCBHC certification." Should this provider class definition be limited to CMHCs and LBHAs with CCBHC certification?

State Round 2 Response (May 16, 2022): No, the provider class definition should not be limited to CMHCs and LBHAs with CCBHC certification because HHSC allows for CMHCs and LBHAs without certification to participate in the DPP BHS. If a CMHC or LBHA does not have certification, the provider will receive a lower Component 2 uniform percent increase with the opportunity to gain certification as a CCBHC and receive the higher Component 2 uniform percent increase.

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CMS Response 6/3/22: We understand that the CMHCs and LBHAs need to submit an application annually to participate in BHS, but:

- i. Can the state please discuss how the CCBHC recertification process works – how often do the CCBHCs need to go through the recertification process?
- ii. Is that why the state maintained the distinction in provider class for CCBHC- certified vs not certified, as some CCBHCs may lose their certification during the SFY 2023 rating period?

State Round 3 Response (June 8, 2022):

- i. Texas CCBHC certification and recertification standards are rooted in SAMHSA’s CCBHC criteria with minor differences where SAMHSA allowed states to make changes in order to comply with state requirements. All reviews include a desk review of policies and procedures, staff interviews, and calls with CCBHC executive leadership.

Texas CCHBCs are recertified every three years. At the three-year mark, each CCBHC undergoes a targeted review in which HHSC considers a select group of criteria based on items HHSC anticipates have changed over the three-year period and items that the CCBHC was still working to implement or improve at the time of certification. At the six-year mark, HHSC conductd a full review, and the review cycle starts over again.

- ii. Yes, the state is maintaining the distinction in provider class for CCBHC-certified vs. non certified to allow LBHAs and CMHCs that may lose CCBHC certification during the SFY 2023 rating period to remain eligible for DPP BHS payments.

11. Preprint Question 27: Given this proposal is for the next rating period, can the state please clarify why it appears that no changes were made to the provider payment analysis?

State Response (April 21, 2022): No changes were made to the provider payment analysis because the payment methodology utilized in SFY2023 remains unchanged from the payment methodology utilized in SFY2022. HHSC did not identify any issues with the SFY2022 payment methodology that would require changes in the SFY2023 payment methodology.

CMS Response 6/3/22: Thank you for updating Table 2 in the revised preprint submission. We have compared the analyses from SFY 2022 to SFY 2023 (see table below).

	Average Base Payment from Plan to Provider	Effect on Total Payment Level of SDP	Total Payment Level
SFY 2022 Providers with and w/o CCBHC certification	40%	56%	96%
SFY 2023 Providers with and w/o CCBHC certification	49%	24%	72%

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Revised SFY 2023 Providers with and w/o CCBHC certification	49%	25%	74%
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- i. Can the state please clarify if the Table 2 provider payment analysis methodology changed from SFY 2022 to SFY 2023?
- ii. Can the state please explain what factors contribute to the changes in total payment level from year 1 to year 2?

State Round 3 Response (June 8, 2022):

- i. The provider payment analysis methodology did not change from SFY 2022 to SFY 2023.
- ii. The variance in the SFY 2022 and SFY 2023 amounts is due to a number of factors, with caseload growth as the main driver specific to DPP BHS. Other factors include changes in the applicant pool with the addition of LBHAs in SFY2023 and in network status changes, as those all play a role when the growth factors are applied to calculate the total size of the program and associated components.. The state has added a row to the chart above with data for revised SFY 2023 providers with and without CCBHC certification.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

12. For any entities that may or may not have taxing authorities and do not receive any state appropriated funds, please describe how the funding for those IGTs is derived. We note that in some of the funding information provided under the various proposals 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. For example, Metrocare in Att. H does not receive appropriations. Where does the allowable state share funding for services provided in that district come from? Will the lack of appropriated funds from Metrocare have any impact on the availability of or payment for services provided in that district?

State Response (April 21, 2022): All participating entities are publicly-owned and -operated. Consistent with 42 C.F.R. § 433.51, the IGT for the program will come from public funds, including from local governmental entities that do generally have taxing authority or may receive general revenue-funded grants. Metrocare is one of many entities formerly under the MHMR structure that are now categorized as a Local Mental Health Authority (LMHA) and/or a Local Intellectual Disability or Developmental Disorder Authority (LIDDA). Although this preprint did not include an Attachment H, we understand that Metrocare, like most local governmental entities, receive funds directly through general appropriation and have access to other sources of funds that are public and eligible for use as the non-federal share, local government appropriations, and commercial patient revenue.

13. 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 the renewal submission.

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State Response (April 21, 2022): At the original time of preprint submission, HHSC had 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.

14. How were the IGTs arranged? Are all of the IGT Entities TX has listed in all Renewals signing an IGT Agreements 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, IGT entities complete a Declaration of Intent form notifying HHSC of the funds that are intended to be transferred. In limited circumstances, the Texas Legislature earmarks specific public funds appropriated to a governmental entity with direction to use such funds in support of the Medicaid program.

CMS Response (5/11/22): What is the purpose of the Declaration of Intent to IGT to the state Medicaid Agency? Is there any expectation from the IGT entities regarding their voluntary contribution of the IGT, meaning are they receiving anything in return for the IGT? If so, what information was provided to these entities to notify them of the amount of IGT that the state may be requesting? Do the IGT entities expect any return of any payment from the local providers that are the recipients of the payments? If so, what information was provided to these entities about rules regarding the reassignment of payments under 42 CFR 447.10?

State Round 2 Response (May 16, 2022): Local governmental entities are prohibited from accepting a non-bona-fide provider-related donation under §1903(w) of the Social Security Act. There is no requirement for a local governmental entity to transfer funds; however, as noted in our prior response, local governmental entities fill out a Declaration of Intent form notifying HHSC of the funds the entity intends to transfer via IGT to allow HHSC to plan accordingly.

CMS Response 6/3/22: Thank you for this information. We urge Texas to gather such information from local entities that contribute to the non-federal share of Medicaid payments to have a full accounting of the entities that contribute to the financing. 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 provided by the state, there appear to be entities that do not have access to tax revenue or appropriations and that may rely on bonds or other debt instruments as a source of non-federal share revenue. We would urge the state to examine the sources of financing that those entities use to source IGTs as a starting point in your oversight efforts and to further work with localities to identify where bonds or debt instruments are used to finance the non-federal share of Medicaid payments. We will continue to follow up on the work of the state oversight body, and reaffirm the state's obligation to ensure that funding for Medicaid payments are derived from allowable sources.

State Round 3 Response (June 8, 2022): We appreciate the feedback on our ongoing monitoring efforts.

15. Can the state elaborate on the ways in which the entities listed in Att. H are units of local government? It is not clear if these are providers or if they are some other entity.

State Response (April 21, 2022): HHSC has provided a list for Attachment F – IGT Entities that clarifies the operational nature of local governmental entities that provide IGT of public funds for use as the non-federal share. Eligible DPP BHS providers are Certified Community Behavioral Health Clinic (CCBHC) and Local Behavioral Health Authorities (LBHAs) and only units of state or local government are permitted to submit an IGT for use as the non-federal share of Medicaid payments. Texas has various classes of entities that are governmental entities operated at the local level, including Local Mental Health Authorities (LMHA), Local Intellectual Disability or Developmental Disorder Authorities (LIDDA), CCBHCs, LBHAs, and others that can be contiguous with a specific county or city, but are a unique unit of local government. Therefore, the county or city designation was not appropriate; however, much like a county or city, these are units of local government with varying sources of public funds, including state appropriation, county appropriations etc. depending on their individual enabling statutes.

16. 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.

17. Can the state please confirm that no local provider participation funds (LPPFs) are being used to finance the IGTs used to fund the non-federal share of Medicaid expenditures?

State Response (April 21, 2022): The state confirms that no local provider participation funds (LPPFs) are being used to finance the IGTs used to fund the non-federal share of Medicaid expenditures for this program.

18. 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](#).

19. 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

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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): Please see response to duplicate question, above.

20. During the 2022 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 2023 are funded?

State Response (April 21, 2022): The state has not changed the manner in which the payments proposed in 2022 are funded. 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.

CMS Response (5/11/22): Regarding question #20, what particular oversight will there be when looking at the use of bonds and other debt instruments to fund the non-federal share for those entities that use those means to fund the IGTs?

State Round 2 Response (May 16, 2022): HHSC has fully formed the Local Funds Monitoring team and has promulgated rules related to the oversight and reporting that will be administered by the team. The implementation of required reporting has begun in accordance with the timelines previously shared with CMS. In addition to these steps, HHSC is evaluating ways to improve oversight of local funds and plans to continue to make these communications publicly available to allow all stakeholders to have transparent access to review CMS concerns. HHSC will continue to allow local governmental entities to transfer any public funds available to them for use as the non-federal share.

CMS Response 6/3/22: Thank you for this information. We urge Texas to gather such information from local entities that contribute to the non-federal share of Medicaid payments to have a full accounting of the entities that contribute to the financing. We will continue to follow up on the work of the state oversight body, and reaffirm the state's obligation to ensure that funding for Medicaid payments are derived from allowable sources.

State Round 3 Response (June 8, 2022): We appreciate the feedback on our ongoing monitoring efforts.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

21. Will the state include BHS 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.

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22. 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.

CMS Response (5/11/22): When does the state and its actuary expect to know if amendments are necessary, and what would necessitate an amendment?

State Round 2 Response (May 16, 2022): After the reconciliation occurs, the actuary will compare, at the rate cell level, what the capitation rates would've been with the reconciled information to the current capitation rates.

CMS Response 6/3/22: We would appreciate if the state's actuary could explain what threshold will be used to determine if an amendment is necessary.

State Round 3 Response (June 8, 2022): At this point the state would like to avoid being too prescriptive in setting a threshold at which an amendment will be required. The state anticipates that the initial analysis will consider variations at the rate cell level within +/- the risk margin to not require an amendment. Additional consideration will have to be given to rate cells that are relatively small that may have larger % variations; however, a rate amendment may be insignificant in the aggregate for such cases for certain MCOs. In other words the analysis will include both an evaluation at the rate cell level and in the aggregate for each MCO to determine whether a rate amendment is necessary.

23. 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.

CMS Response (5/11/22): Can the state please clarify/confirm - we understand that the state directed payment is identified as a separate component of the PMPM capitation rates for each rate cell, and this amount also includes the non-benefit cost loads cited in the state's response.

State Round 2 Response (May 16, 2022): The state confirms this response.

24. 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 Component 1, after accounting for MCO fees detailed in question 23.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

25. 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.

26. 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.

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27. CMS appreciates the evaluation findings presented for BHS and may have additional follow-up questions at a later date.

CMS Response (5/11/22): Thank you for providing preliminary baseline statistics and performance targets for six BHS evaluation measures. Will the state be able to provide CMS preliminary data (provider-specific and EQRO) and preliminary performance targets in August 2022 for all evaluation measures? Please note that CMS will require that the state submit complete baseline data (Year 1 data) for all four payment arrangements (CHIRP, TIPPS, RAPPs and BHS), along with associated performance targets, in the Year 3 preprint.

State Round 2 Response (May 16, 2022): HHSC will be able to share preliminary provider-reported data with CMS in August 2022, and would welcome a meeting to discuss it.

However, since preliminary EQRO data will be available to HHSC no later than August 31, 2022, HHSC will not be able to share preliminary EQRO data with CMS by August 2022. HHSC will be able to share preliminary performance targets for all evaluation measures with CMS once all preliminary provider-reported data and preliminary EQRO data have been received and reviewed by HHSC.

The state acknowledges and plans to submit complete baseline data (Year 1 data) for all four payment arrangements, along with associated performance targets, in the Year 3 preprint.