

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: 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: 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: 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. **Updated State Response during Round 2:** 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:

- i. The revised preprint maintains the total dollar estimate to be \$635 million for SFY 2023. Does the state anticipate this total dollar amount changing with the final submission?
- ii. Based on available data to-date, can the state provide a revised accounting of what the actual spend has been to date for TIPPS for SFY 2022?

State Round 3 Response:

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

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CMS Response 7/7/22: The state indicates in preprint question 4 that the estimated federal share is \$295,572,799.83 and the estimated non-federal share is \$442,436,687.89. Can the state please confirm that this is correct?

State Round 4 Response: The state apologizes for this inadvertent typographical error. The preprint question 4 has been revised to display the correct federal and non-federal share amounts.

ii. As of May 31, 2022, total payments for the SFY2022 TIPPS directed payment program are approximately \$340 million for the first six months of the program. Based on the total expenditures for the first six months, the estimated annualized total expenditure for SFY2022 will be \$680 million. The estimated annualized total expenditure is subject to change.

CMS Response 7/7/22: Does the state have a revised estimated annualized total expenditure for SFY 2022 that can be shared with CMS?

State Round 4 Response: Annualized expenditures for SFY22 are estimated to be \$687,501,738, but the rating period will not conclude until August 31, 2022, so that total is subject to change.

- 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

CMS Response 7/7/22: Based on the final total dollar amount estimate (\$738M), can the state please provide updated estimates for Component 1, Component 2, and Administration, profit margin, or premium tax?

State Round 4 Response:

- i. Component 1: \$452,552,988
- ii. Component 2: \$174,058,841
- iii. Component 3: \$69,623,537
- iv. Administration, profit margin, or premium tax: \$41,774,122

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

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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: 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: 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: 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 Response Round 2: The state affirms the above deadline is correct.

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

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

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- 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: The reconciliation for the TIPPS program will be based on actual utilization and an independent reconciliation will be completed for Component 1 and 2.

CMS Response 6/3/22: During the SFY 2022 TIPPS 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 Components 1 and 2 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 Components 1 and 2 would fluctuate proportionately as Component 1 and 2 is designed to be equal to a percentage of the overall program value. Does the state plan to use this reconciliation methodology for TIPPS Components 1 and 2 for SFY 2023?

State Round 3 Response: 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 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: 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: 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.

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	SFY 2022	Initial SFY 2023	Revised SFY 2023	Final 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.	Per member per month \$34.13 for class 1 and \$27.44 for class 2	Per member per month \$35.04 for class 1 and \$27.66 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	Per member per month 82.95% for class 1 and 166.14% for class 2	Per member per month 82.95% for class 1 and 166.14% for class 2
Component 3 (uniform percent increase)	58.64%	56.57%	99.56%	70.54%

State Response: 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.

Updated State Response during Round 2: 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): When does the state anticipate being able to provide the final component and non-benefit cost provision amounts to CMS?

State Round 2 Response: 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: We have updated the table above to reflect the revised SFY 2023 uniform increases. Can the state please discuss the factors that contributed to the changes in the dollar and percent increases? In looking from SFY 2022 to SFY 2023, there appears to be significant increases for Component 2, Class 2 and Component 3.

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State Round 3 Response: The variance in the SFY 2022 and SFY 2023 amounts is due to a number of factors, with caseload growth as the main driver. Additionally, in SFY2022 the UPL for TIPPS was limited to no more than \$600 million, while this year the UPL is not limited and is set based on the total room available, which results in a larger program even with fewer participants. Other factors include changes in the applicant pool, difference in room for the program based on the average commercial rate, and changes in network status - all of which play a role when the growth factors are applied to calculate the total size of the program and associated components.

CMS Response 7/7/22: We have updated the table above to reflect the final uniform increases.

- i. Can the state please explain why, for this year, the UPL is not limited, whereas for SFY 2022 it was?
- ii. Can the state please also further elaborate as to what is meant by “changes in network status”?

State Round 4 Response:

- i. In Year 1, HHSC limited the size of the program as other funding streams, including NAIP were still available. In Year 2, HHSC authorized utilization of more of the total of the ACR UPL (\$696M) to acknowledge the additional costs associated with providing quality care for these providers, particularly in light of rising costs associated with inflation and the ongoing public health emergency, as well as the end of NAIP payments to physicians. The state confirms the changes made by CMS related to the table above and in Attachment C based on receipt of final network status information from Actuarial Analysis.
 - ii. In-network status for the participating NPIs/Provider fluctuates throughout the course of a program year. HHSC PFD captures the network status of the participating NPIs/Providers at the time of enrollment, but we are aware that network status is subject to change based on the provider and MCO arrangements.
- 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: 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. **Updated State Response during Round 2:** 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): When does the state anticipate being able to provide to CMS the specific increases in Attachment C?

State Round 2 Response: 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.

- ii. Is it also correct that the uniform percent increases for Component 3 will not change?

State Response: 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: 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.

CMS Response (5/11/22): Can the state further clarify how the state defines Provider Class 3? The current definition indicates that physician practice groups other than those specified in Class 1 and 2 are eligible. However, the state's response above seems to indicate that there is further narrowing of the class by a taxonomy list. Can you clarify if there are physician practice groups other than those specified in Class 1 and 2 that bill CPT codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215 that are not eligible for the uniform increase in Provider Class 3? If so, please explain the additional criteria used to define Provider Class 3 and update Attachment D.

State Round 2 Response: The state defines a Class 3 provider as a physician group that is not a HRI or IME, is enrolled with a Managed Care Organization (MCO) for the delivery of Medicaid covered benefits, is located in a service delivery area with at least one

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sponsoring governmental entity, and has served at least 250 unique Medicaid managed care clients in the prior state fiscal year.

As an additional qualifying criteria for Class 3 providers, if the NPI submitted by a Class 3 provider in their application does not bill with a taxonomy code on the approved Component 3 taxonomy list, the physician group would not be eligible for the Component 3 rate increase. Class 3 providers who enroll and meet required criteria are eligible for the associated uniform increase for this component only.

CMS Response 7/7/22: Can the state please update Attachment D (response to preprint question 20.b) to reflect these additional criteria for a Class 3 provider?

State Round 4 Response: In the May preprint submission, HHSC updated the list of taxonomy codes in Attachment D to include OBGYN taxonomies and expanded Component 3 participation for certain Class 3 providers. The criteria for Class 3 providers did not change so no additional update to Attachment D is needed at this time.

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

State Response: 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.

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

State Response: 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.

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

State Round 2 Response: For SFY 2023 (Year 2), HHSC received 90 TIPPS applications.

CMS Response 6/3/22: Thank you for providing the "TIPPS PGY 1 and PGY2 Application Data Comparison by Provider and NPI" spreadsheet.

1. In looking at the SFY 22 column,

- a. It looks like there were 121 applicants for PGY2 TIPPS, and a total of 446 NPIs. Is that correct?

State Round 3 Response: That is correct. There were 121 applicants for PGY2 TIPPS, with a total of 446 NPIs.

- b. Is the NPI for Hamilton County Hospital District correct? It currently reads: 1.67956296117101E+29

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State Round 3 Response: The correct NPIs for Hamilton County Hospital District are 1679562961, 1710135553, 1629215041.

2. In looking at the SFY 23 column, it looks like there were 82 applicants for PGY2 TIPPS, and a total of 344 NPIs. Is that correct?

State Round 3 Response: That is correct. There are a total of 82 applicants for PGY2 TIPPS with a total of 344 NPIs.

3. Can the state please discuss what factors it believes contributed to the decrease in applicants for SFY 23?

State Round 3 Response: The state is unaware of specific reasons for the decrease in applications for SFY 23. Anecdotally, some providers did voice concerns related to the delayed timeline for approval of SFY22 and cited the delay as a potential reason for not participating in SFY23.

4. Are the number of applicants subject to change or is this the final count?

State Round 3 Response: This is the final count of applications, and HHSC is no longer accepting applications for TIPPS SFY 23.

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)	Initial SFY 2023 Total Payment Level Estimate (as a % of ACR)	Revised SFY 2023 Total Payment Level Estimate (as a % of ACR)	Final SFY 2023 Total Payment Level Estimate (as a % of ACR)
Health-Related Institutions (HRI) Physician Group	100%	81%	96%	96%
IME Physician Group	84%	84%	92%	92%
Other Physician Group	60%	48%	56%	58%

State Response: 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

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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.

Updated State Response during Round 2: 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): When does the state anticipate being able to provide the final component and non-benefit cost provision amounts to CMS? Also does the state's payment level analysis account for the additional taxonomy changes for Class 3?

State Round 2 Response: 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. The revised payment level analysis will account for the additional taxonomy changes for Class 3. 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: We have updated the table above to reflect the revised SFY 2023 total payment level estimates. Can the state please discuss the factors that contributed to the changes from SFY 2022 to SFY 2023, particularly for the HRI Physician Group class?

State Round 3 Response: Please note that the chart above for the Revised SFY 2023 Total Payment Level Estimate has been updated. The variance in the SFY 2022 and SFY 2023 amounts is due to a number of factors, with caseload growth as the main driver. Additionally, in SFY2022 the UPL for TIPPS was limited to no more than \$600 million, while this year the UPL is not limited and is set based on the total room available, which results in a larger program even with fewer participants. Other factors include changes in the applicant pool, difference in room for the program based on the average commercial rate, and changes in network status - all of which play a role when the growth factors are applied to calculate the total size of the program and associated components.

CMS Response 7/7/22: We have updated the table above to reflect the provider payment analysis in Table 2 of the preprint.

State Round 4 Response: HHSC confirms that the changes made by CMS to the table reflect the final percentages. The state has updated the response to Question 28.

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

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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: 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.

CMS Response (5/11/22): Please provide any updates on when the updated actuarial certification for year 2 will be available.

State Round 2 Response: HHSC can confirm it is targeting July 15-18, 2022 to submit the fiscal year 2023 actuarial reports to CMS.

CMS Response 7/7/22: The state's response to preprint question 28 indicates, "The methodology for TIPPS year 2 is assumed to be similar to year 1, HHSC will update actuarial certification upon completion of provider enrollment." Is this sentence still relevant? Please remove or address as applicable.

State Round 4 Response: Yes, HHSC confirms that the methodology for TIPPS Year 2 is consistent with the methodology for TIPPS Year 1. The actuarial certification will be updated for Year 2.

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: 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: 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: 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: 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: 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 +/-

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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.

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: 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. Is this correct?

State Round 2 Response: The state confirms this response.

11. Are the plans directed to use a specific portion of the capitation rates paid to them to pay out Component 1?

State Response: 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: 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

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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.

CMS Response (5/11/22): We appreciate the state's responses. The state's response to question #12 did not quite seem to address the questions raised by CMS. Can the state provide any specifics regarding where the funding for the specific entities in the state's IGT entity list will be coming from?

State Round 2 Response: HHSC does not prospectively assess what funds a specific governmental entity may choose to use in a future transfer to support the Medicaid program. Local governments are permitted to transfer any public funds available to them. HHSC's Local Funds Monitoring team will retrospectively gather information from local governments about sources of public revenues through the reporting and oversight processes that are being implemented.

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: We appreciate the feedback on our ongoing monitoring efforts.

CMS Response 7/7/22: We note that we continue to have concerns with any IGTs, used to fund these payments, that are derived from any source other than state or local tax revenue, state appropriated funds, or from organizations that do not have general taxing authority. We remain

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interested in seeing how the state oversight body undertakes the oversight of these funding mechanisms in light of our review.

State Round 4 Response: The state appreciates CMS' interest in our monitoring activities and plans to provide implementation updates to CMS as a separate matter from state directed payment approval processes upon request.

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: 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: 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: 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.

CMS Response (5/11/22): Regarding the state's response to question #15, is there any expectation from the IGT entities regarding their voluntary contribution of the IGT? 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: Local governmental entities are prohibited from accepting a non-bona-fide provider-related donations 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

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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: We appreciate the feedback on our ongoing monitoring efforts.

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: 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](#).

CMS Response (5/11/22): We appreciate the state's response to question #16. In the event that the oversight body is not set up before the IGTs are sent to the Medicaid agency, and payments are made to the providers, are there any interim steps that will be taken to ensure that all funds transferred meet the federal requirements for IGTs?

State Round 2 Response: 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

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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: We appreciate the feedback on our ongoing monitoring efforts.

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: 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): CMS continues to have concerns about the source of the non-federal share being derived from debt/loans. Prior to the formation and implementation of the state's oversight body, are there any interim steps that will be taken to ensure that all funds transferred and used to fund the non-federal share meet the federal requirements for IGTs? What particular oversight will there be when looking at the use of bonds and other debt instruments to fund the non-federal share?

State Round 2 Response: 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 (6/3/2022): Thank you for this information. 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: We appreciate the feedback on our ongoing monitoring efforts.

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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: 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: 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.

CMS Response (5/11/22): CMS does not have additional questions on the LPPFs at this time. However, we continue to harbor the same hold harmless concerns as we did for the SFY 2022 pre-prints for CHIRP, TIPPS, and RAPPs that are financed by LPPFs.

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State Round 2 Response: Noted. HHSC continues to work with HHS OIG on the LPPF audit that is now underway. HHSC has a high level of confidence that the local governments in Texas that operate an LPPF are compliant with all applicable federal laws and regulations.

CMS Response 7/7/2022: CMS does not have additional questions on the LPPFs at this time. Please note that we continue to harbor the same hold harmless concerns as we did for the SFY 2022 pre-prints for CHIRP, TIPPS, and RAPPs that are financed by LPPFs.

State Round 4 Response: Noted.

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: 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: 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: 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: 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

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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.

CMS Response (5/11/22): Thank you. 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: 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.