TX_VBP_NF_Renewal_20240901-20270831 (QIPP)
CMS Round 2 Question Set
August 5, 2024

Please see Round 2 CMS questions listed below in green text. State responses to Round 2 Questions (submitted to CMS 8/9/24) are in purple.

Section II: Type of State Directed Payment [Q8-9]

1. Please affirm that the payments required under this payment arrangement will **only** be made for (please confirm each separately):
    a. Performance using at least one performance measure as defined in 42 CFR 438.6(a) as a quantitative measure with a numerator and denominator that is used to monitor performance at a point in time or track performance over time, of service delivery, quality of care, or outcomes as defined in § 438.320 for enrollees. **State Response**: Texas affirms payments made under the QIPP will only be made for performance using at least one performance measure as defined in 42 CFR 438.6(a) as a quantitative measure with a numerator and denominator that is used to monitor performance at a point in time or track performance over time, of service delivery, quality of care, or outcomes as defined in § 438.320 for enrollees.
    b. The payment is **not** conditioned upon administrative activities, such as the reporting of data nor upon the participation in learning collaboratives or similar administrative activities. **State Response**: Texas affirms payments made under the QIPP are not conditioned upon administrative activities, such as the reporting of data nor upon the participation in learning collaboratives or similar administrative activities.
    c. The payment is conditioned upon a common set of performance measures across all the payers and providers specified in the SDP. **State Response**: Texas affirms payments under QIPP are conditioned upon a common set of performance measures across all the payers and providers in the SDP.
    d. The payment is tied to the delivery of services for Medicaid beneficiaries covered under the Medicaid managed care contract for a performance measurement period not to exceed the length of the rating period and that does not precede the start of the rating period listed in the response to question 1 by more than 12 months. **State Response**: Texas affirms payments under QIPP are tied to the delivery of services for Medicaid beneficiaries covered under the Medicaid managed care contract for a performance measurement period that does not exceed the length of the rating period. Furthermore, the performance measurement period does not precede the start of the rating period, September 1, 2024, by more than 12 months.
    e. The payment is made based on performance using measurable targets, which are attributable to the performance by the providers in delivering services to enrollees in each of the State's managed care program(s) for which the SDP applies that demonstrate maintenance or improvement over baseline data on all metrics that will be used to measure the performance. **State Response**: Texas affirms the

intention is for payments under QIPP to be made based on performance using measurable targets, which are attributable to the performance by the providers in delivering services to enrollees in each of the State's managed care program for which the SDP applies that demonstrate maintenance or improvement over baseline data on all metrics that will be used to measure the performance. Please see also see response to question 27.

Section IIA: Value-Based Payments (VBP)/Delivery System Reform (DSR) [Q10 – 15]

2. The baseline statistics for the measures listed in Addendum Table 1.A are listed as "not yet available." As noted in the email on June 10, 2024, CMS noted that the regulation at 43 CFR 438.6(c)(2)(vi)(B)(*4*) states that "if the State directed payment for which written prior approval is required under paragraph (c)(2)(i) of this section conditions payment upon performance, the payment to providers under the State directed payment must identify baseline statistics on all metrics that will be used to measure the performance that is the basis for payment to the provider from the MCO, PIHP or PAHP." CMS is in receipt of the measure specifications documentation the state submitted June 25. While we appreciate the additional detail, CMS does not consider this documentation sufficient to meet the requirements at 42 CFR 438.6(c)(2)(vi)(B)(*4*). CMS would recommend the state consider one of the following options:
    a. Revise the measures used in the preprint to use measures for which the State has baseline data. CMS notes that in the completeness email and follow-up technical assistance call on June 26, 2024 that the state expects to have baselines available by the end of June 2024 for most measures and will be able to update the preprint with this information at that time. If the state is in receipt of that updated data, the state could use that data and update the preprint to include these baseline statistics and the Baseline Year in columns D and E in Addendum Table 1.A.
    State Response: The state is providing an updated version of Addendum Table 1.A with quality measure baselines for participating facilities. For new quality measures without available data for CY2023, the state is including baselines based on CY2023 data from analogous quality measures and will make a technical correction to the preprint to update the baselines when new measure data become available from CMS. The state expects final baseline data to be available for all measures before calculating performance.

    Although the state continues to believe that 42 CFR 438.6(c)(2)(vi)(B)(*4*) does not require the requested edits to Table 1.A, the state offers the edits described above in the spirit of collaboration and with the hope that the revised Table 1.A will be sufficient to allow CMS to move towards approval of this preprint.

    Under the new managed care rules, effective no later than the first rating period for contracts beginning on or after July 9, 2024, if a "State directed payment … conditions payment on performance, the **payment to providers** … must identify baseline statistics on all metrics that will be used to measure the performance that

is the basis for payment to the provider… .” (emphasis added); 42 CFR 438.6(c)(2)(vi)(B)(4) and 42 CFR 438.6(c)(8)(ii). In Texas, the first rating period that begins on or after July 9, 2024, is the rating period that begins on September 1, 2024, and ends on August 31, 2025.

The new regulatory language does not require a State to provide the baseline statistics before the beginning of the applicable rating period. Rather the regulation requires the *payment to providers* to identify the baseline statistics on all metrics used to measure the performance that is the basis for the payment. Thus, it is HHSC’s belief that, if before or at the time the payment is made to a provider, the baseline statistic is identified for the provider, the plain language of the regulation is met. Additionally, a state is not required to "complete and submit all required documentation ... before the start date of the directed payment "until the first rating period … beginning on or after 2 years after July 9, 2024.” 42 CFR (c)(2)(viii) and 42 CFR 438.6(c)(8)(iii). Similarly, states have “until the first rating period … beginning on or after 2 years after July 9, 2024,” to comply with the requirement that all directed payment programs be “specifically described and documented in the MCO’s … contracts, [including] the approved baseline statistics for all measures.” 42 CFR 438.6(c)(5)(iii)(D)(3) and 42 CFR 438.6(c)(8)(iii).

CMS Round 2, 8/5/24: Thank you for providing the updated baselines; these updated baselines fulfill the requirement at 42 CFR 438.6(c)(2)(vi)(B)(*4*), which is applicable to this rating period. The regulatory requirement at 42 CFR 438.6(c)(2)(vi)(B)(*4*) require that the baselines for pay for performance measures be identified.

Please note that any change to the baseline data would require submission of a SDP preprint amendment subject to CMS review and approval. CMS would also like to clarify that the regulatory requirement does require that the baselines for pay for performance measures be identified in the preprint.

We did also again want to clarify that the requirement at 42 CFR 438.6(c)(2)(vi)(B)(*4*) which is applicable to this rating period differs from the regulatory requirements at 42 CFR 438.6(c)(2)(viii) and 438.6(c)(5)(iii)(D)(3). The state is correct that both of these later regulatory provisions do not apply to this rating period for Texas. We have provided the clarification sent on July 5, 2024 here for reference; no action is being asked in response:

“We appreciate the follow-up the state provided as well asking about the regulatory requirements at 42 CFR 438.6(c)(2)(viii) and 438.6(c)(5)(iii)(D)(3). The state is correct that both of these later regulatory provisions do not apply to this rating period for Texas. However, the requirement at 42 CFR 438.6(c)(2)(vi)(B)(*4*) is applicable for this rating period. CMS cannot move ahead

to approval of this preprint without the baselines for these measures identified; this differs from the requirement that the preprint be submitted prior to the start of the payment arrangement (42 CFR 438.6(c)(2)(viii)), which is applicable for the first rating period beginning on or after July 9, 2026. It also differs from the requirement that the that the contract between the state and the MCO, PIHP or PAHP must include a description of the SDP including identify[ing] the baseline statistics for all measures against which performance will be measured (42 CFR 438.6(c)(5)(iii)(D)(3), which is applicable for the first rating period beginning on or after July 9, 2026. We did provide the state several options in the Round 1 questions for the state to consider and are happy to meet again to discuss."

State Response 8/9/24: The state appreciates this clarification and understands that any change to the baseline data will require submission of an SDP preprint amendment subject to CMS review and approval.

b. If the state does not have baseline data for certain measures, the state could identify those for which it does have baseline data and remove those metrics for which baseline data is not available. If the state is able to identify baseline data for metrics at a later date, it could choose to amend the preprint at that time to include those metrics. Please note, if the state chooses to amend the payment methodology by adding or changing the metrics used to determine provider payments, the state will need to account for such changes in the related contracts and rate development documentation.
c. If the state cannot identify the baseline data for the metrics and does not want to remove such metrics, the state can wait and resubmit the preprint once the baseline data has been obtained.

3. Since the state is seeking a multiyear approval for this VBP preprint, CMS asks the state to verify if the total dollar amount listed in Q4 [$1.75B] is for the annual period or the full, multiyear period?

State Response: Texas affirms the $1.75B is for an annual rating period.

4. Since the state is seeking a multi-year approval for this VBP preprint, will the state be updating the baselines and/or targets in Addendum Table 1.A? Or will the state be using the same baselines and targets for each of the three years?

State Response: The state plans to update participating facility baselines and performance targets each year, as annually updated baselines are the best way to measure and ensure continued improvement or maintenance of high performance year over year.

Additionally. 1 Tex. Admin. Code § 353.1304 requires the state to publish quality measure selection and to hold a public hearing about program structure and measurement methodologies each year. Although the state is pursuing a multi-year preprint approval,

Texas will continue to operate under the annual cycle established in 1 Tex. Admin. Code § 353.1304.

5. CMS requests the state develop and describe a plan for implementing a multi-year payment arrangement, including a plan for multi-year evaluation, and the impact of a multi-year payment arrangement on the state's goals and objectives in the state's quality strategy in § 438.340.

   State Response: The state will continue to complete annual evaluations of provider performance and to measure progress towards and achievement of goals and objectives from the state's quality strategy. Although the state is pursuing a multi-year preprint approval, Texas will continue to operate under the annual cycle established in 1 Tex. Admin. Code § 353.1304 and required by STC 35 in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver. See responses to Q4 above for more information on annual requirements and Q25 below for more information on program evaluation.

6. CMS asks the state to affirm that it will not make any changes to the payment methodology, or magnitude of the payment, described in the contract for all years of the multi-year payment arrangement without CMS prior approval.

   State Response: Texas affirms no changes to the payment methodology, or magnitude of the payment for all years of the multi-year payment arrangement will be implemented without prior approval from CMS.

Section III: Provider Class and Assessment of Reasonableness [Q20-28]

7. Please indicate if the state is directing plans to pay non-network providers and/or network providers under this payment arrangement.

   State Response: The state is only directing plans to make payments to network providers under this payment arrangement.

8. In May 2024, CMS published the 2024 Medicaid and CHIP Managed Care Final Rule. Effective for rating periods beginning on or after July 9, 2024, SDPs that include the certain service types must comply with the requirements at 42 CFR 438.6(c)(2)(iii). Specifically, the total payment rate for each SDP for which written prior approval is required for inpatient hospital services, outpatient hospital services, nursing facility services or qualified practitioner services provided at an academic medical center as defined in 438.6(a) must not exceed the average commercial rate. To demonstrate compliance, states must provide an average commercial rate demonstration that complies with the requirements at 42 CFR 438.6(c)(2)(iii)(A) and a total payment rate comparison that complies with the requirements at 42 CFR 438.6(c)(2)(iii)(B)

a. Preprint Question 20: The state indicated the provider class for the preprint is one or more of the following: inpatient hospital services, outpatient hospital services, nursing facility services and/or qualified practitioner services at an academic medical center. CMS requests confirmation from the state on the provider class.
State Response: Texas confirms the provider class is nursing facility services, to include non-state government-owned nursing facilities and private nursing facilities.

b. Additionally, to comply with the requirement under 438.6(c)(2)(iii)(A), CMS requests the state confirm that the data used to develop the ACR demonstration:

☐ is the average rate paid for services by the highest claiming third-party payers for the specific services included in the SDP as measured by claims volume?

☐ is specific to the State?

☐ is for the three most recent and complete years prior to the rating period of the initial request?

☐ includes the total reimbursement by the third-party payer and any patient liability, such as cost sharing and deductibles?

☐ excludes payments to FQHCs, RHCs, and from any non-commercial payers, such as Medicare?

☐ excludes any payment data for services or codes that the applicable Medicaid MCOs, PIHPs, or PAHPs do not cover?

State Response: Texas confirms that the ACR demonstration meets all of the requirements described above.

9. Additionally, to comply with the requirements under 438.6(c)(2)(iii)(B), CMS requests the state confirm that the total payment rate analysis included in Table 2:

☐ Is for the applicable rating period;

☐ Uses payment data that are specific to each service included in the preprint; and

☐ Describes each of the components of the total payment rate as a percentage of ACR for each of these services included in the preprint.

State Response: Texas confirms that the total rate payment analysis included in Table 2 meets all of the requirements described above.

10. Can the state also clarify – is the ACR demonstration provided specific to both the class and the service or just the service?

State Response: Texas confirms the ACR demonstration is specific to nursing facility class and service.

Section IV: Incorporation into Medicaid Managed Care Plan Contract(s) [Q29]

11. In May 2024, CMS published the 2024 Medicaid and CHIP Managed Care Final Rule. Effective for rating periods beginning on or after July 9, 2026, 42 CFR 438.6(c)(5)

requires that SDPs must be specifically described and documented in the MCO's PIHP's, or PAHP's contracts and requires minimum documentation standards for what is included in state contracts. These minimum documentation standards vary by the type of SDP. We encourage states to review these requirements and plan appropriately.

State Response: Acknowledged. Texas is reviewing the program design and the state's contracts with MCOs for changes that will need to be made for compliance with federal regulations that will take effect in 2026 but do not apply to the rating period for which the state is currently seeking approval.

Section V: Incorporation into Actuarial Rate Certification [Q30-Q33]

12. CMS would like to include the state's actuaries on the approval email for this state directed payment preprint to ensure that the details within the approved preprint (e.g. total dollar amount) are accurately documented within the applicable rate certification(s) in accordance with the documentation requirements outlined in the most recent Medicaid Managed Care Rate Development Guide. Please provide the name and email address of at least one actuary who is responsible for producing the rate certification(s) in which this state directed payment will be documented.

    State Response: Michael Joyner (Michael.joyner@hhs.texas.gov), Jeremy Vacek (Jeremy.vacek@hhs.texas.gov).

13. We would appreciate understanding how the state and actuary intend to incorporate payment in the capitation rates.

    State Response: QIPP will be incorporated the same as previous years, as an add-on included in the total capitation rates. The add-on will include MCO fees for administrative fees (0.125%), risk margin (1.75%), and premium tax (1.75%).

14. Please explain how the state's actuaries have enough information without the performance measures' baseline calculations to appropriately account for a reasonable estimate of this payment arrangement in the STAR+Plus Medicaid managed care rates.

    State Response: Because all program funds remain in QIPP, the actuaries do not require specific baselines to determine that the QIPP rates are actuarially sound. Pursuant to 1 Tex. Admin. Code § 353.1302(g), QIPP funds will be paid to managed care organization through four components of the STAR+PLUS nursing facility managed care per member per month (PMPM) capitation rates. The managed care organizations' distribution of QIPP funds to the enrolled nursing facilities will be based on each nursing facilities performance related to the quality metrics. The allocation of funds across qualifying non-state government-owned and private nursing facilities will be proportional, based upon historical Medicaid days of nursing facility service. Pursuant to 1 Tex. Admin. Code § 353.1302(g)(5)(B), funds that are non-disbursed due to a failure of one or more nursing

facilities to meet performance requirements ("non-disbursed funds") will be distributed across qualifying nursing facilities who have demonstrated achievement of a quality measure designated by HHSC, QIPP SFY2025 Non-Disbursed Funds Measure (texas.gov). Therefore, the Star+Plus Medicaid managed care rates are based on the annual program funding size with an understanding the distribution of the funding will be distributed to qualifying nursing facilities who have demonstrated achievement of performance requirements.

15. CMS also requests clarification from the state about how the payments will flow from state to plan to provider for each component.

    Component 1: It appears that the state is targeting $770,000,000 (44% of the $.175B) to Component 1 and that the allocation will be based on historical Medicaid days of nursing facility services, but that the payments from the plans to the providers will be made quarterly.

    a. Is the state and its actuary determining an amount per historical Medicaid day of nursing facility services based on the $770,000,000 target for Component 1 for those nursing facilities in the qualifying provider class? Is that how the state's actuary is incorporating Component 1 into capitation rates as a base adjustment? If not, explain how the state and its actuaries will be incorporating component 1 into the base rate PMPMs.
       State Response: Pursuant to 1 Tex. Admin Code 353.1302(g), the total value of: Component 1 is equal to 44 percent of the total program size; Components 2 and 3 are equal to 20 percent of the total program size, respectively; and Component 4 is equal to 16 percent of the total program size. The percentage of each Component to the total program size was determined based on prior QIPP program years' Component payments. Texas determines an amount for the component to include in the capitation rates based on the historical utilization of nursing facilities in the qualifying provider class and available program funding. However, the full program value is included in the capitation rates paid during the program period on a per member, per month basis.
    b. Is the state and its actuary then projecting anticipated performance on the 5 measures for Component 1 for the nursing facilities in the qualifying provider class?
       State Response: As described in #14 response above, the Star+Plus Medicaid managed care rates are based on the annual program funding size with an understanding that all available program funds will be distributed to qualifying nursing facilities who have demonstrated achievement of performance requirements. Therefore, there is no need to project anticipated performance for the qualifying nursing facilities because the amount of funds available to nursing facilities, in the aggregate, remains the same regardless of the performance of individual nursing facilities.

c. For the historical Medicaid days of nursing facility services that will be used for allocating the funds, what time period is this data from? Is this the same time period/data used for the underlying development of the capitation rates for these populations/services? If not, how does it differ and why?
State Response: Pursuant to 1 Tex. Admin. Code § 353.1302(d), the annualized historical Medicaid utilization from the most recent Medicaid cost reporting period was utilized to allocate the funds. Because Texas collects nursing facility cost reports biennially, 2022 is the most recent Medicaid cost reporting period for which data is available. This data source is collected and financially examined, in accordance with 1 Tex. Admin. Code § 355.106. If a facility did not complete a 2022 Medicaid cost report, Texas uses the most recently financially examined cost/accountability report. The collection of the 2024 nursing facility cost reports will occur in 2025. The base period, however, for SFY 2025 capitation rates across all Medicaid managed care programs is SFY 2023. As described above, QIPP funds are included in an MCO's per member per month capitation rates and then directed to providers through a scorecard issued by HHSC.

d. Do all the nursing facilities eligible for this component have historical Medicaid days of nursing facility services for the time period listed above? Or are some of the facilities new to Medicaid managed care and/or this SDP provider class? If so, how does the state and its actuary anticipate adjusting for new facilities?
State Response: Yes, all participating providers have historical utilization. Texas uses annualized data from the most recent cost report. Facilities that do not have a historical Medicaid data are ineligible for participation.

e. Will the state or its actuaries be making any additional adjustments or updates to trend factors for this specific Component of this SDP that differ from planned adjustments for the broader capitation rates? If so, please describe and provide the rationale for these differences.
State Response: Trending is not necessary for QIPP because payments to nursing facilities are tied to the delivery of services for Medicaid beneficiaries covered under the Medicaid managed care contract but are not tied to enrollee on utilization during the rating period.

f. How is the state directing its managed care plans to pay the nursing facility providers for achievement on Component 1? Will the state be determining if the nursing facilities met achievement of the required targets for the measures on Component 1 or will the plan be doing so based on the state's instructions?
State Response: Texas issues a scorecard that directs managed care plans to distribute payments to enrolled nursing facilities after the nursing facilities demonstrate achievement of performance requirements. Texas will be determining if the nursing facility providers met achievement of the required targets for the measures in the component. For an example of monthly and quarterly payment scorecards, please visit the Provider Finance Department QIPP webpage here.

g. Will the state's instructions to the plan include an amount per historical Medicaid day of nursing facility services based on their performance or will the state's

instructions to the plan include an amount to be paid by quarter for each nursing facility based on their performance?
State Response: Texas's payment instructions to the managed care plans include a quarterly payment amount based on each qualified nursing facility's performance. In previous rating periods, some QIPP payments were made monthly, and some were made quarterly. Beginning with this rating period, all QIPP payments will be made quarterly.

h. Will the state be requiring the plans to hold a certain amount of their capitation back to comply with the payments under Component 1?
State Response: No, Texas does not require the managed care plans to hold back a certain amount of their capitation rate back for the component. QIPP does not include a withhold arrangement.

i. The state indicates that they are targeting $770,000,000 for Component 1; is the plan at risk if the performance of the nursing facilities is better than anticipated? Is it possible that the total amount paid out by the plans will differ from the $770,000,000?
State Response: Managed care plans are not at risk based on the performance of individual nursing facilities in meeting their metrics. The capitation rate assumes all program funds will be paid to enrolled facilities, less MCO fees for administrative fees, premium taxes and risk margin. There is, however, potential risk for the managed care plans due to potential variation between forecasted caseload data and actual caseload for the program period.

Component 2: It appears that the state is targeting $350,000,000 (20% of the $.175B) to Component 2 and that the allocation will be based on historical Medicaid days of nursing facility services, but that the payments from the plans to the providers will be made quarterly.

a. Is the state and its actuary determining an amount per historical Medicaid day of nursing facility services based on the $350,000,000 target for Component 2 for those nursing facilities in the qualifying provider classes? Is that how the state's actuary is incorporating Component 2 into capitation rates as a base adjustment? If not, explain how the state and its actuaries will be incorporating Component 2 into the base rate PMPMs.
State Response: Please see response above for Component 1a.

b. Is the state and its actuary then projecting anticipated performance on the 3 measures for Component 2 for the nursing facilities in the qualifying provider classes?
State Response: Please see response above for Component 1b.

c. For the historical Medicaid days of nursing facility services that the state references will be used for allocating the funds, what time period is this data from? Is this the same time period/data used for the underlying development of the capitation rates for these populations/services? If not, how does it differ and why?

State Response: Please see response above for Component 1c.

d. Do all the nursing facilities eligible for this component have historical Medicaid days of nursing facility services for the time period listed above? Or are some of the facilities new to Medicaid managed care and/or this SDP provider class? If so, how does the state and its actuary anticipate adjusting for new facilities?
   State Response: Please see response above for Component 1d.
e. Will the state or its actuaries be making any additional adjustments or updates for trend factors for this specific Component of this SDP that differ from planned adjustments for the broader capitation rates? If so, please describe and provide the rationale for these differences.
   State Response: Please see response above for Component 1e.
f. How is the state directing its managed care plans to pay the nursing facility providers for achievement on Component 2? Will the state be determining if the nursing facilities met achievement of the required targets for the measures on Component 2 or will the plan be doing so based on the state's instructions?
   State Response: Please see response above for Component 1f.
g. Will the state's instructions to the plan include an amount per historical Medicaid day of nursing facility services based on their performance or will the state's instructions to the plan include an amount to be paid by quarter for each nursing facility based on their performance?
   State Response: Please see response above for Component 1g.
h. Will the state be requiring the plans to hold a certain amount of their capitation back to comply with the payments under Component 2?
   State Response: Please see response above for Component 1h.
i. The state indicates that they are targeting $350,000,000 for Component 2; is the plan at risk if the performance of the nursing facilities is better than anticipated? Is it possible that the total amount paid out by the plans will differ from the $350,000,000?
   State Response: Please see response above for Component 1i.

Component 3: It appears that the state is targeting $350,000,000 (20% of the $.175B) to Component 3 and that the allocation will be based on historical Medicaid days of nursing facility services, but that the payments from the plans to the providers will be made quarterly.

a. Is the state and its actuary determining an amount per historical Medicaid day of nursing facility services based on the $350,000,000 target for Component 3 for those nursing facilities in the qualifying provider classes? Is that how the state's actuary is incorporating Component 3 into capitation rates as a base adjustment? If not, explain how the state and its actuaries will be incorporating Component 3 into the base rate PMPMs.
   State Response: Please see response above for Component 1a.

b. Is the state and its actuary then projecting anticipated performance on the 3 measures for Component 3 for the nursing facilities in the qualifying provider classes?
State Response: Please see response above for Component 1b.

c. For the historical Medicaid days of nursing facility services that the state references will be used for allocating the funds, what time period is this data from? Is this the same time period/data used for the underlying development of the capitation rates for these populations/services? If not, how does it differ and why?
State Response: Please see response above for Component 1c.

d. Do all the nursing facilities eligible for this component have historical Medicaid days of nursing facility services for the time period listed above? Or are some of the facilities new to Medicaid managed care and/or this SDP provider class? If so, how does the state and its actuary anticipate adjusting for new facilities?
State Response: Please see response above for Component 1d.

e. Will the state or its actuaries be making any additional adjustments or updates for trend factors for this specific Component of this SDP that differ from planned adjustments for the broader capitation rates? If so, please describe and provide the rationale for these differences.
State Response: Please see response above for Component 1e.

f. How is the state directing its managed care plans to pay the nursing facility providers for achievement on Component 3? Will the state be determining if the nursing facilities met achievement of the required targets for the measures on Component 3 or will the plan be doing so based on the state's instructions?
State Response: Please see response above for Component 1f.

g. Will the state's instructions to the plan include an amount per historical Medicaid day of nursing facility services based on their performance or will the state's instructions to the plan include an amount to be paid by quarter for each nursing facility based on their performance?
State Response: Please see response above for Component 1g.

h. Will the state be requiring the plans to hold a certain amount of their capitation back to comply with the payments under Component 3?
State Response: Please see response above for Component 1h.

i. The state indicates that they are targeting $350,000,000 for Component 3; is the plan at risk if the performance of the nursing facilities is better than anticipated? Is it possible that the total amount paid out by the plans will differ from the $350,000,000?
State Response: Please see response above for Component 1i.

Component 4: It appears that the state is targeting $280,000,000 (16% of the $.175B) to Component 4 and that the allocation will be based on historical Medicaid days of nursing facility services, but that the payments from the plans to the providers will be made quarterly.

a. Is the state and its actuary determining an amount per historical Medicaid day of nursing facility services based on the $280,000,000 target for Component 4 for those nursing facilities in the qualifying provider classes? Is that how the state's actuary is incorporating Component 4 into capitation rates as a base adjustment? If not, explain how the state and its actuaries will be incorporating Component 4 into the base rate PMPMs.
State Response: Please see response above for Component 1a.

b. Is the state and its actuary then projecting anticipated performance on the 2 measures for Component 4 for the nursing facilities in the qualifying provider class?
State Response: Please see response above for Component 1b.

c. For the historical Medicaid days of nursing facility services that the state references will be used for allocating the funds, what time period is this data from? Is this the same time period/data used for the underlying development of the capitation rates for these populations/services? If not, how does it differ and why?
State Response: Please see response above for Component 1c.

d. Do all the nursing facilities eligible for this component have historical Medicaid days of nursing facility services for the time period listed above? Or are some of the facilities new to Medicaid managed care and/or this SDP provider class? If so, how does the state and its actuary anticipate adjusting for new facilities?
State Response: Please see response above for Component 1d.

e. Will the state or its actuaries be making any additional adjustments or updates for trend factors for this specific Component of this SDP that differ from planned adjustments for the broader capitation rates? If so, please describe and provide the rationale for these differences.
State Response: Please see response above for Component 1e.

f. How is the state directing its managed care plans to pay the nursing facility providers for achievement on Component 4? Will the state be determining if the nursing facilities met achievement of the required targets for the measures on Component 4 or will the plan be doing so based on the state's instructions?
State Response: Please see response above for Component 1f.

g. Will the state's instructions to the plan include an amount per historical Medicaid day of nursing facility services based on their performance or will the state's instructions to the plan include an amount to be paid by quarter for each nursing facility based on their performance?
State Response: Please see response above for Component 1g.

h. Will the state be requiring the plans to hold a certain amount of their capitation back to comply with the payments under Component 4?
State Response: Please see response above for Component 1h.

i. The state indicates that they are targeting $280,000,000 for Component 4; is the plan at risk if the performance of the nursing facilities is better than anticipated? Is it possible that the total amount paid out by the plans will differ from the $280,000,000?

State Response: Please see response above for Component 1i.

16. Please note that in May 2024, CMS published the 2024 Medicaid and CHIP Managed Care Final Rule. Effective July 9, 2024, retroactive adjustment to the capitation rates, as outlined in 42 CFR 438.7(c)(2), resulting from a SDP must be a result of adding or amending any SDP consistent with the requirements at 42 CFR 438.6(c) or a material error in the data, assumptions or methodologies used to develop the initial capitation rate adjustment such that modifications are necessary to correct the error.

    State Response: Acknowledged.

Section VI: Funding for the Non-Federal Share [Q43-Q38]

17. 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: Texas 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.

18. Please affirm that the SDP's financing of the non-federal share complies with all Federal legal requirements for the financing of the non-Federal share, including but not limited to 42 CFR 433, subpart B.

    State Response: The state affirms that the SDP's financing of the non-Federal share complies with all Federal legal requirements for the financing of the non-Federal share, including but not limited to 42 CFR 433, subpart B, as those requirements are currently applicable in Texas.

19. Section 1902(a)(2) of the Social Security Act obligates the state to pay that amount regardless of the amount of IGT or other non-federal share received from other sources. Please describe what occurs in instances where the funds derived from the hospital districts or counties are less than the amount the state is obligated to pay out under the approved contracts. Conversely, please describe what occurs when the funds derived from the hospital districts or counties are in excess of the amount the state is obligated to pay out under the approved contracts.

    State Response: It is not clear from the plain language of Section 1902(a)(2) of the Social Security Act that that section applies to a directed payment program that is authorized outside of the state plan. In Texas, all of the directed payment programs, including QIPP, are authorized under the Texas Healthcare Transformation and Quality Improvement Program section 1115(a) Medicaid demonstration, not the state plan. Regardless of the applicability of Section 1902(a)(2) of the Social Security Act, a lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the state plan.

In all instances of prior program operation, due to the widespread local support for the continuation of QIPP, local governments have voluntarily transferred the amount the state is obligated to pay out under the approved contracts. In the event that local governments transfer more funding than is utilized to support the program, Texas refunds to local governments any unused funds proportional to the amount that was initially transferred by the local government in support of the program. If local governmental entities transfer less than the amount the state is obligated to pay out under the approved contracts, the state would use state general revenue.

20. Please provide a listing of all nursing facilities associated with each transferring entity, as applicable.

    State Response: Please see Attachment 1 for a list of all nursing facilities owned by a transferring entity. Any program funding received via IGT is collected at the SDA level but pooled statewide, so there is no 1:1 correlation between transferring entities and nursing facilities.

21. Can the state explain the ownership and operational status of county hospital authorities or hospital districts that own and/or operate nursing facilities outside of their county's boundaries? What is the nature of these relationships?

    State Response: The specific authority of a hospital district or hospital authority to own nursing facilities, regardless of the location of the nursing facility, varies based on the Texas Constitution and the enabling legislation and/or local ordinance that created the hospital district or authority. Generally both hospital districts and hospital authorities are authorized to identify and address the healthcare demands in their jurisdiction, particularly in areas where there may be a lack of services. The nursing facilities typically remains under the oversight of the county hospital authority or hospital district, particularly with regards to regulatory compliance.

    In accordance with 1 Tex. Admin. Code § 353.1302(c)(1)(C), in order to participate in QIPP as a non-state government owned nursing facility, the facility be located in the state of Texas in the same county as, or if separate counties, a contiguous county of, the non-state governmental entity taking ownership of the facility; must be owned by the non-state governmental entity for no less than four years prior to the first day of the program period; or must be able to provide documentation of activities that demonstrate an active partnership that have occurred in the prior nine months before application as well as a detailed plan for maintaining the partnership in the months following the application date through the end of the program period. The criteria for demonstrating an active partnership between a nursing facility and the non-state governmental entity that own the facility are detailed in 1 Tex. Admin. Code § 353.1302(c)(1)(E).

22. Please describe the relationship between Hospital Authorities and their partnerships with for profit entities that run the nursing facilities.

State Response: Typically, a hospital authority or hospital district retains ownership of, and exercises oversight of, the nursing facility, while the for-profit entity manages the facility's daily operations. In such cases, the hospital authority or hospital district maintains control over the facility to ensure it meets health care needs while leveraging the resources, expertise, and economies of scale of the for-profit partner to maximize access to and quality of care. Under such arrangements, the for-profit entity would be responsible for day-to-day operations, staffing, and financial management, while the hospital authority is responsible for ensuring the facility complies with state and federal regulations and meets quality standards.

23. Where are the following transferring entities obtaining the funds necessary for them to IGT for these payments?
    a. Coryell County Memorial Hospital Authority - $28.4 million. **State Response**: The Coryell County Memorial Hospital Authority obtains the funds it uses for IGT from eligible public sources of funding. Based on federal fiscal year 2022 reporting provided to HHSC by the hospital authority, the hospital authority had over $72 million in net patient revenue, which was sufficient to cover the IGT it submitted for the non-federal share of QIPP. The Coryell Hospital Authority also reported that it has bonding authority, receives some funds appropriated by another local governmental entity, and contract revenue from another local governmental entity – all of which are also eligible sources of public funding.

    b. Eastland Memorial Hospital District - $30.9 million. **State Response**: Please note that, as a hospital district, the Eastland Memorial Hospital District does have taxing authority. As CMS advised Texas in 2021, Texas established a monitoring program to examine the underlying sources of local non-federal share of all types. Texas is actively reviewing the Eastland Memorial Hospital District's funding sources. Thus far, our review has found that the district obtains the funds it uses for IGT from eligible public sources of funding, including its ad valorem taxing authority, net patient revenue, fees (court fees, fines, permits, etc.), debt instruments, and contract revenue from another local government entity – all of which are also eligible sources of public funding. Specifically in our review, we have not identified any bonds or other debt instruments that involve Medicaid providers (or provider-related entities) participating in the arrangements through the purchase of bonds or other debt instruments and/or the receipt of payments supported by the revenue raised. CMS expressed in 2021 that their concern was that provider-related entities were participating in purchasing debt instruments, and there is no evidence that this is occurring.

    c. Fannin County Hospital Authority – $33.79 million. **State Response**: As CMS advised Texas in 2021, Texas established a monitoring program to examine the underlying sources of local non-federal share of all types. Texas is actively reviewing the Fannin County Hospital Authority's funding sources. Thus far, our review has found that the authority obtains the funds it uses for IGT from eligible public sources of funding, including net patient revenue, fees (court fees, fines, permits, etc.), debt instruments, and contract revenue from another local government entity – all of which

are also eligible sources of public funding. Specifically in our review, we have not identified any bonds or other debt instruments that involve Medicaid providers (or provider-related entities) participating in the arrangements through the purchase of bonds or other debt instruments and/or the receipt of payments supported by the revenue raised. CMS expressed in 2021 that their concern was that provider-related entities were participating in purchasing debt instruments, and there is no evidence that this is occurring.

Texas has previously advised CMS, including during the question and response period related to directed payment program approvals in 2021, that at least one of the hospital authorities CMS is identifying have bonding authority. For your convenience, you can find the previous question and answer document that includes information related to Coryell Hospital Authority that Texas has previously submitted to CMS at the website link included in the footnotes below.[1] The responsive section can be found on page 84, under the section titled "Sources of Non-Federal Share (IGTs, Bonds, and Debt Instruments).

As discussed with CMS in 2021 and noted in the June 2024 MACPAC report[2], Texas did establish the Texas Local Funds Monitoring program, which has enabled us to provide the specific information related to Coryell County Memorial Hospital Authority, Eastland Memorial Hospital District, and Fannin County Hospital Authority. Through Texas' process of collecting and verifying information provided by local governmental entities, Texas is able to reaffirm its numerous prior assurances that funding from local sources are derived from permissible sources. In federal fiscal year 2022, local governmental entities reported an array of public sources of funding including, but not limited to: appropriations from the state; appropriations from another unit of local government (such as a county providing a portion of its local sales tax to its local public hospital); patient revenue (where the local governmental entity is a provider of services); bonds; fees; lottery and state settlement proceeds (such as tobacco funding); contracts with the state or other unit of government for services (i.e. a university compensating a public hospital for residency and fellowship training opportunities); tuition (as is the case with state-owned teaching hospitals); fair market value leases for commercial space; etc.

Local funding is actively reviewing FY2022 reporting for Fannin County Hospital Authority and has not made a final determination of the funding it submitted for the non-federal share of the QIPP program.

CMS Round 2, 8/5/24: State Response 8/9/24: Responses in-line for clarity.
In the response to our questions related to the state directed payments under the QIPP program the state explained that it has established a Local Funds Monitoring team that is

[1] cms-feedback-with-state-response-march-2022.pdf (texas.gov)
[2] MACPAC Report published June 18, 2024; available at: https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-Chapter-1-Improving-the-Transparency-of-Medicaid-and-CHIP-Financing.pdf

responsible for collecting information from each entity that provides local funds as the non-federal share of Medicaid payments beginning in 2022 after CMS previously raised questions about the source of local funds used to finance aspects of the QIPP programs. The state noted that the oversight mechanism would include a combination of self-reported quarterly data, review of public record data, and analysis of each funding source and related documentation. In the prior iterations of CMS review of the QIPP state directed payment, CMS noted the need for careful oversight related to the use of bonds to fund the non-federal share of this program as bonds are forms of debt instruments. The state previously explained that bonds may be purchased by anyone, the bond funds are then used to finance a project, and the payments and principal are paid out through the project's revenue. We continue to have concerns over the potential for bonds to include non bona-fide provider related donations (see section 1903(w) of the Act) when used as the source of non-federal share for Medicaid payments because such funds are owed back to the bondholders which could potentially include health care providers or related entities as discussed in federal regulations at 42 CFR 433.54.

The state acknowledges CMS' concern about this string of hypothetical scenarios; however, the state continues to have no indication that providers or provider-related entities are purchasing bonds issued by local governmental entities that IGT.

The state appreciates CMS' interest in our monitoring activities, and we will continue to provide CMS updates on our progress at any time as a separate matter from state-directed payment approval processes upon request.

Within the current responses to non-federal share financing questions for the QIPP program, the state discusses using "fair market value leases of commercial spaces" as a source to fund the non-federal share. This form of financing does not appear to have been raised in prior iterations of these payment proposals. CMS has concerns about the potential for the use of leases of commercial space to involve non bona-fide provider related donations to the extent that a lessee is a health care provider or related entity. In order for CMS to understand the existing commercial lease arrangements which appear to be used as a source of non-federal share of Medicaid payments, please provide responses to the questions below.

1. Please confirm that the commercial leases referenced in the response are commercial leases that do not involve providers or provider-related entities as described in federal regulations at 42 CFR 433.54. Please provide the names of the lessees and lessors that are involved in the arrangements used to fund the non-federal share of Medicaid payments under the QIPP program. The leases referenced in the above response were hypothetical sources of public funds that could be used by a political subdivision as a source of IGT. As part of our routine monitoring, we request copies of any agreements (including leases) between governmental entities and providers that receive payments under any program the governmental entity supports via IGT or CPE. As a reminder, the state implemented its enhanced oversight through the Local Funds Monitoring team in

phases, beginning with local governmental entities that supported payments to hospitals, then adding local governmental entities that supported payments for non-hospital services (like QIPP), and most recently, adding local governmental entities that supported payments via CPE. We are still in active review of funding sources that support QIPP payments and have not completed review of the documentation we have received thus far.

Based on our preliminary review of FY 2022 data, none of the local governmental entities you have identified above support QIPP received lease payments from a provider that is eligible to receive payments under QIPP, or an entity related to a provider eligible to receive payments under QIPP. Under 42 CFR 433.54(b), "[p]rovider-related donations will be determined to have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity… ." Because the amounts of any leases held by the relevant entities do not have a direct or indirect relationship to Medicaid payments made to nursing facilities under QIPP, no lease payments made to the relevant local governmental entities could be considered a non-bona fide donation under 42 CFR 433.54 for the purposes of QIPP.

Please note that this preprint approval process has gone on so long, it is unlikely that Texas nursing facilities will be able to receive QIPP payments at the start of the contract year. We would appreciate CMS' efforts to expedite its review of this preprint to avoid further delay of payment to providers serving some of the most vulnerable Medicaid beneficiaries. If CMS would like additional information regarding the thousands of pages in documentation we received in connection with our routine and robust oversight, we are glad to provide that information outside of the preprint approval process.

2. If the commercial leases involve providers or related entities, please indicate which providers or related entities are engaged in lease arrangements with the state and/or locality and confirm that such leases are executed at fair market value. Please provide supporting information describing the process for determining that the leases are negotiated at fair market value. Please see above response.

3. Please provide an example of an MOU or agreement between any provider or related entity and a unit of local government that describes the terms of a lease agreement. Please see above response.

Section VII: Quality Criteria and Framework for all payment arrangements [Q39-Q44]

24. Please note that in April 2024, CMS issued the 2024 Medicaid and CHIP Managed Care Final Rule. Effective for rating periods beginning on or after July 9, 2027, 42 CFR 438.6(c)(2)(iv) includes additional requirements for what is included in the written

evaluation plan submitted with the SDP, including a commitment to submit the evaluation report as described in 42 CFR 438.6(c)(2)(v) if the final SDP cost percentage exceeds 1.5 percent. CMS will publish additional guidance, but we encourage states to begin reviewing these requirements and planning appropriately.

State Response: Acknowledged. Texas has reviewed the requirements for the written evaluation plan as outlined in 42 CFR 438.6(c)(2)(iv), and has begun planning for implementation. HHSC will review the additional guidance published by CMS and will reach out to CMS in advance of the effective date of this provision if technical assistance is needed.

25. Question 44 **Evaluation metric(s)**

Consistency of metrics between rating periods

Thank you for providing the evaluation metrics the state will use to monitor the impact of the payment arrangement. We noticed the metrics included in Table 2-5 of the state's evaluation plan differ from the metrics included in the preprint for the SFY 2024 contract rating period (Year 7 of the payment arrangement).

These tables include the following new metrics:

- Percent of residents who have depressive symptoms
- Percent of residents with new or worsened bowel or bladder incontinence
- Percent of residents who used antianxiety or hypnotic medication
- Percent of residents who have/had a catheter inserted and left in their bladder
- Percent of residents experiencing one or more falls with major injury.
- Percent of residents who lose too much weight.
- Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days
- Reported Total Nursing Staff (HPRD)
- Reported Certified Nursing Assistants (CNA) HPRD
- Reported Licensed Nursing HPRD

To allow for the monitoring of trends, CMS asks the state to provide data for all years of the payment arrangement, including the baseline, when reporting each new evaluation metric. Please confirm whether the state intends to calculate the new metrics using data from each year of the payment arrangement.

State Response: As with other program evaluation measures, the state intends to set baselines for the new measures listed above at the average performance rate of all participating providers in the first program year of the measure's inclusion. For all measures listed above, the evaluation baseline will come from SFY2025 performance, which will cover the measurement period from 7/1/2024 to 6/30/2025.

26. Question 44 **Baseline year**

Baseline statistics remain consistent

We also noticed the state removed several metrics that were previously included in the SFY 2024 evaluation plan. For example, the 'Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine' was previously included in the prior evaluation plan but is missing from the current evaluation plan. Please explain why the state updated its evaluation metrics.

State Response: Most of the program evaluation measures align with the pay-for-performance quality measures included in the four program components. Improvement in the measure highlighted above is no longer incentivized as a pay-for-performance measure within the program, and so the state removed it from the program evaluation plan. The measure was removed to make room for new MDS-based quality measures in the re-organized program component structure.

Texas will continue to review the appropriateness of included quality measures and performance targets on an annual cycle. See the response to Q4 above for more information on annual requirements.

The only evaluation measures that do not align with pay-for-performance measures included in the program itself are based on claims data related to hospital and emergency room visits. Although improvement in these claims-based measures is not incentivized within the program directly, these measures constitute key indicators of the state's progress towards meeting its quality goals and objectives. Because of that, Texas intends to continue evaluating QIPP on how improvement in the pay-for-performance measures also impacts these two areas of facility performance.

27. Question 44 **Evaluation findings**

Evaluation data is limited to Medicaid managed care enrollees and services rendered by participating providers

Thank you for providing SFY 2022, 2023, and 2024 evaluation findings. Will the state please provide an update on its progress limiting the MDS data to Medicaid managed care enrollees receiving services from providers participating in the payment arrangement?

State Response: With regards to payments made under QIPP, the state would need additional technical assistance to limit MDS quality measure calculations to only the Medicaid managed care population with enough certainty to determine program quality measure payments. Going through the Acumen help desk has not resulted in the level of detail we need to ensure sufficiently accurate replication of the MDS rates to determine provider payments. The level of technical assistance we need requires someone to review the code and/or data we are using to help us identify why the state's calculations do not match Acumen's calculations exactly. It is our understanding that Acumen is not available under their CMS contract for that level of technical assistance. Is there another source for that technical assistance you could help us access?

With regards to the program evaluation, the state is confident it will be able to limit MDS-based evaluation measure calculations to the Medicaid managed care population only, as these calculations work on program-wide averages and trends over time, rather than relying on individual provider performance within discrete measurement periods.