

Round 4 Question Set

July 5, 2022

SECTION I: DATE AND TIMING INFORMATION

1. Preprint Question 4:

- a. CMS asks the state to confirm if the amount provided in question 4 includes provisions for non-benefit costs such as margin, administrative load, and/or taxes and fees? If so, CMS 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. Please describe why the amount provided in response to question 4 is the same estimate as what was provided in last year's preprint.

State Response: The total available funding for SFY 2023 is expected to remain unchanged from SFY 2022.

CMS Response 7/5/22: The state indicates in preprint question 4 that the estimated federal share is \$449,550,000 and the estimated non-federal share is \$659,450,000. Can the state please confirm that this is correct? For SFY 2022, the state reported that the estimated federal share was \$692,450,000 and the estimated non-federal share was \$407,550,000.

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.

- c. Please provide estimates of the share of the total dollars provided in response to question 4 that is for:
 - i. Component 1 - \$484,605,000
 - ii. Component 2 - \$159,808,000
 - iii. Component 3 - \$239,712,000
 - iv. Component 4 - \$176,000,000
 - v. Administration, profit risk margin, and premium tax. \$39,875,000

SECTION II: TYPE OF STATE DIRECTED PAYMENT

2. Preprint Question 8:

- a. In Attachment A:

- i. The state references Attachment A1, but it was not submitted. Please provide Att A1 or other documentation that provides clarity on the reconciliation process.
 - a. Please also confirm all payments (including the interim payments based on historical data for Component 1) will be reconciled to actual utilization data during the SFY 2023 rating period? The QIPP SFY 2022 approval letter stated, "CMS will not approve the state directed payment if Component 1 or other parts of the payment arrangement condition payment on services rendered during a previous rating period; the requirement of a reconciliation threshold or similar

structure with a threshold higher than zero percent will not be considered sufficient to meet this regulatory requirement.”

State Response: The reference to attachment A1 in Attachment A was an oversight, please disregard. The interim allocation of funds, based on historical Medicaid fee-for-service and STAR+PLUS days of service, across qualifying non-state government-owned nursing facilities will be reconciled to the actual distribution of Medicaid nursing facility days of service across these nursing facilities during the program period; the actual distribution of funds will be captured by Health and Human Services Commission’s (HHSC’s) Medicaid contractors for Medicaid days of service 120 days after the last day of the program period. Please see the attached file detailing the reconciliation process for SFY 2023.

- b. The state indicated the following during the SFY 2022 review of QIPP Component 1. Has any of this changed for SFY 2023 QIPP payments?
1. 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.
 2. 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 all components, the state’s actuary will review the results and determine if QIPP’s capitation rate changes are necessary to adhere to actuarial soundness requirements. The state affirms the second above statement for QIPP.

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

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

- c. As part of the SFY 2022 preprint review, the state indicated, “the state intends to maintain the size of Component 1 as a percentage of the overall program value; however, the gross value of Component 1 may change if the overall program value fluctuates from the estimated value. This fluctuation would be a result of changes in caseload from the forecasted caseload for the fiscal year. However, the payments will still be reconciled against actual utilization, so the actual percentage of program value compared to actual utilization may result in a different percentage rate increase than the estimated rate increase, which is based upon historical utilization and estimated program values.” Is this still the case for SFY 2023?

State Response: The state affirms this response.

- ii. Under Component 1, it says, NF must “serve at least one Medicaid member per payment period”. In Attachment A for SFY 2022, the state says, “one Medicaid member per reporting period”. Can the state please explain how this is operationalized and if there was a change from SFY 2022 to SFY 2023?

State Response: Payment period and reporting period are interchangeable in this case. There is no operational change between SFY22 and SFY23.

- iii. Under Component 4, it says, “HHSC designates one quality metric for Component Four that entails staged performance targets over the four quarters of the program year”. Can the state please clarify what you mean by this statement (i.e., designating one quality metric)?

State Response: This metric is “staged” because there are different performance requirements associated with each quarter; however, the metric remains the same and is the only metric in Component 4.

CMS Response (5/11/22): According to Attachment C, there are 4 quality metrics for Component 4 – percent of residents assessed and appropriately given the Pneumococcal vaccine, percent of residents assessed and appropriately given the seasonal influenza vaccine, NF maintains active infection control program that includes pursuing improved outcomes in antibiotic stewardship, and NFA and DON demonstrate recent completion of “Nursing Home Infection Preventionist Training Course” developed by CMS and the CDC. This seems at odds with the state’s response that metric remains the same and is the only metric in Component 4. Can the state please clarify and appropriately revise the preprint?

State Round 2 Response: Table 1 in Attachment C has been revised.

There is one quality metric – “Facility has active infection control program that includes pursuing improved outcomes in vaccination rates and antibiotic stewardship”. However, there are different performance targets associated with the same metric staged differently for each quarter.

In Quarters 1 and 3, NFs fulfill the quality metric by attesting to and submitting documents supporting all key antibiotic stewardship and infection control elements.

In Quarter 2, NFs fulfill the quality metric by attesting to and submitting documentation that the NFA and DON have completed “Nursing Home Infection Preventionist Training Course” developed by CMS and the CDC.

In Quarter 4, NFs must meet performance targets in both the vaccination measures to meet the quality metric- (i) percent of residents assessed and appropriately given the Pneumococcal vaccine and (ii) percent of residents assessed and appropriately given the seasonal influenza vaccine.

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- b. From the SFY 2022 review, CMS understood the total values of each component would be as follows. Can the state please confirm this is still accurate for SFY 2023?
 - i. Component 1 = total value equals 110% of the non-federal share of the QIPP.
 - ii. Component 2 = total value equals 40% of remaining QIPP funds after accounting for the funding of Components 1 and 4.
 - iii. Component 3 = total value equals 60% of remaining QIPP funds after accounting for the funding of Components 1 and 4.
 - iv. Component 4 = total value of Component 4 equals to 16% of the total funds of the QIPP.

State Response: The state affirms this response. There are no changes in component allocation from SFY 2022 to SFY 2023.

- c. The state indicates in preprint question 6c that this SFY 2023 preprint submission proposes quality metrics/benchmark changes. Can the state describe the changes from SFY 2022 and update the below table accordingly?

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Component	Class Eligible	Brief Description	SFY 2022	SFY2023	State Response
Component 1 (QAPI)	NSGO NFs	A uniform percent increase dispersed as a monthly payment. The monthly payment is based on historical utilization with a reconciliation threshold if utilization differs from the historical utilization by 18% of zero percent and is contingent upon monthly submission of a QAPI Validation Report form and data related to a NF-specific performance improvement project (PIP).	NF must initiate a PIP and must report monthly on their progress made on their PIP.	No changes. Texas, please confirm?	The reconciliation threshold was reduced from 18% to zero starting in SFY22 program year. As a Condition of Participation, the PIP reporting frequency changed from monthly in SFY22 to two times per program year in SFY23. Note: this PIP is focused on a CMS long-stay MDS quality measure.
Component 2 (Registered Nurse Workforce Development)	Both NFs	Monthly incentive payment if some or all metrics achieved (met/unmet). The 3 measures are equally weighted – if NF meets performance targets for all measures, they will receive all available funds for this component. The 3 measures are: <ol style="list-style-type: none"> NF increased the number of Registered Nurse hours from the federal requirement of 8 hours by 4 additional hours on at least 90 percent of days (1/3); NF increased the number of Registered Nurse hours from the federal requirement of 8 hours by 8 additional hours on at 	The third measure is now based on having a workforce development program/PIP and monitoring outcomes. In previous years, the measure was based on the submission of a recruitment and retention plan.	State removed the third measure and the performance targets for measures 1 and 2 changed. Texas, please confirm?	Measures and metrics remain unchanged in SFY 2023. As a Condition of Participation, PIP reporting frequency changed from monthly in SFY22 to two times per program year in SFY23. Note: this PIP is focused on a topic of workforce development.

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		<p>least 90 percent of days (1/3);</p> <p>3. NF has a workforce development program in the form of a PIP that includes a self-directed plan and monitoring outcomes (1/3).</p>			
<p>Component 3 (Minimum Data Set (MDS) CMS Quality Measures)</p>	<p>Both NFs</p>	<p>Quarterly incentive payment based on achievement of performance measures. The 4 MDS measures are equally weighted – if NF meets performance targets for all measures, they will receive all available funds for this component. To achieve a measure, the NF must demonstrate either:</p> <ol style="list-style-type: none"> 1. 5% improvement over NF-specific baseline each quarter. Baseline is set at the most recent NF-specific four-quarter average; OR 2. 5% improvement over program-wide benchmark each quarter after Quarter 1. Program-wide benchmark is set at national average. <p>The 4 MDS long-stay measures are:</p> <ol style="list-style-type: none"> 1. Percent of high-risk residents with pressure ulcers (1/4). 2. Percent of residents who received an antipsychotic medication (1/4). 	<p>The measure “Percent of residents with a urinary tract infection (long stay)” was moved from Component 4 to Component 3. The performance targets are now based on quarterly improvement over NF-specific baseline or over program-wide benchmark each quarter after Quarter 1.</p>	<p>No changes. Texas, please confirm?</p>	<p>Correct. See response to Q6.a.</p>

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		<p>3. Percent of residents whose ability to move independently has worsened (1/4).</p> <p>4. Percent of residents with a urinary tract infection (1/4).</p>			
Component 4 (Infection Prevention and Control Program)	NSGO NFs	<p>Quarterly incentive payment based on achievement of quarterly staged measures. All quarterly performance targets must be met to earn an incentive payment for the component. The quarterly staged measures are:</p> <ol style="list-style-type: none"> 1. For quarters 1 and 3 – NF maintains active infection control program that includes pursuing improved outcomes in antibiotic stewardship. NF must demonstrate ongoing adherence to seven elements of infection control and antibiotic stewardship. 2. For quarter 2 - NF reviews and updates infection control policies. 3. For quarter 2 - Nursing Facility Administrator (NFA) and Director of Nursing (DON) demonstrate recent completion of "Nursing Home Infection Preventionist Training Course" developed by CMS and the CDC. NF 	The MDS measure "Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)" is newly added for SFY 2022, The quarterly staged measures are also new for SFY 2022.	State removed the quarter 2 staged measure: "NF reviews and updates infection control policies". Texas, please confirm?	Yes, that is correct.

		<p>must provide certificate of completion for required staff.</p> <p>4. For quarter 4 – two MDS measures:</p> <ul style="list-style-type: none"> a. Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (long stay) b. Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) <p>For the two MDS measures in Component 4, a NF must improve over its NF-specific baseline by 5% or perform better than the national benchmark on both vaccination measures to earn payment in quarter 4.</p>			
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SECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

3. For Components 2-4, please affirm that the payments required under this payment arrangement will **only** be made for performance tied to the delivery of services for Medicaid beneficiaries covered under the Medicaid managed care contract for the SFY 2022 rating period **only** and that the payment will not be made for performance tied to the delivery of services for individuals who are uninsured, nor performance related to the delivery of services covered by another insurer (e.g. Medicare), or covered through the state fee-for-service program.

State Response: Consistent with CMS’s January 2021 SMDL (#21-001), payments are conditioned on the delivery and utilization of services covered under the contract for the applicable rating period. The state affirms that the QIPP payments will be applied only to Medicaid services under the relevant managed care contract. For example, for the MDS

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measures in Components 3 and 4, the state uses the facility-level numerators and denominators from CMS Care Compare to evaluate each NF's achievement. If the NF met or exceeded the performance requirement for the measure, it is eligible to earn a payment, with the payment amount based on the services delivered during the rating period.

CMS Response (5/11/22): Can the state please provide CMS an update on its efforts to use raw MDS data in the calculation of MDS measures that are tied to payment?

State Round 2 Response: The State is conducting an analysis of MDS quality measure methodology to identify discrepancies in the State's facility-level results and revise codes as needed. The State may reach out to CMS with follow-up questions.

CMS Response (6/3/22): Please discuss the timing for using the raw MDS data for purposes of payment calculations.

State Round 3 Response: The state expects to complete its analysis and revisions in time to use raw MDS data to calculate performance results for NFs in SFY2023. This will ensure the results used to determine payments for MDS measures are based on Medicaid managed care beneficiaries only.

4. In Q11 of the preprint, Attachment B captures the state's response.
 - a. Preprint Question 11: The state notes in Attachment B that, "For state fiscal year 2022, QIPP will include four components." Please update the response to correctly read 2023.
State Response: Thank you. Pre-print Attachment B has been revised to reflect this correction.
 - b. The state clarifies in Attachment B that: "The quality metrics will be equally weighted (*within a component*) for payment each month or quarter, as appropriate" (emphasis on the italic). Is this state make an operational change how the quality metrics are weighted for SFY 2023?
State Response: No operational changes are being made to how the quality metrics are weighted for SFY2023.
5. Preprint Question 12 (Attachment C):
 - a. For Component 2:
 - i. Is it correct that the state removed the following measure from Component 2: "NF has a workforce development program in the form of a PIP that includes a self-directed plan and monitoring outcomes"?
State Response: Correct. Component 2 Metric 3 is a uniform percent increase and not a quality measure. As developed for the SFY 2022 program year, the requirement once attached to Component 2 Metric 3 has been designated as a condition of participation in the program. A NF that fails to submit reports on progress in the workforce development PIP will be subject to remediation. Failure to respond will result in removal from the program and all funds earned may be recouped.

- ii. For Metric 1 (NF maintains 12 hours of RN coverage per day), has the performance target changed? For SFY 2022, the state indicated, “Met if NF maintains 4 additional hours for 90% of days in the month”. Attachment C for SFY 2023 says, “NF maintains 12 hours of RN coverage per day.”
State Response: No, the performance target has not changed. “4 additional hours [beyond the CMS-mandated 8 hours]” is equivalent to “12 hours of RN coverage.” The facility must still maintain this coverage for at least 90% of the days in the month.
 - iii. For Metric 2 (NF maintains 16 hours of RN coverage per day), has the performance target changed? For SFY 2022, the state indicated, “Met/Not Met if NF maintains 8 additional hours for 90% of days in the month”. Attachment C for SFY 2023 says, “NF maintains 16 hours of RN coverage per day.”
State Response: No, the performance target has not changed. “8 additional hours [beyond the CMS-mandated 8 hours]” is equivalent to “16 hours of RN coverage.” The facility must still maintain this coverage for at least 90% of the days in the month.
- b. For Component 3: Is it accurate that there were no changes to the performance measures or performance targets for SFY 2023?
State Response: Correct. While the baselines and benchmarks are set each program year, the structure and methodology for Component 3 remain the same.
- c. For Component 4:
 - i. For the Quarter 1 and 3 Metric (NF maintains active infection control program that includes pursuing improved outcomes in antibiotic stewardship), has the performance measure changed? For SFY 2022, the state indicated, “NF must demonstrate ongoing adherence to seven elements of infection control and antibiotic stewardship”. Attachment C for SFY 2023 says, “met” if facility completes assessment of Infection control program requirements for seven core elements of antibiotic stewardship, submits supporting evidence and observational audits for hand hygiene and PPE usage as well as facility-specific antibiogram report.”
State Response: No, the performance measure has not changed between SFY2022 and SFY2023 for the Quarter 1 and 3 Metric (NF maintains active infection control program that includes pursuing improved outcomes in antibiotic stewardship). The specific elements required have been updated for SFY 2023 in line with updated publications from the CDC. Nursing facilities (NFs) submit antibiograms and observational audit data on hand hygiene and PPE compliance. NFs also attest to commitment to implementation of ‘Seven Core Elements of Antibiotic Stewardship for Nursing Homes,’ using a checklist published by CDC.

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- ii. Is it correct that the state removed the following measure from Component 4: “NF reviews and updates infection control policies”?

State Response: That is correct.

- d. In Component 4, why does the state plan to continue having only non-state government-owned nursing facilities be eligible for Component 4, and not including private nursing facilities?

State Response: Texas would consider the classes eligible for Component 4 in the future, but also believes that as the component is focused on a topic (infection control) that we consider a matter of public health, publicly owned facilities have a unique responsibility for advancing public health.

6. Preprint Question 13:

- a. The QIPP SFY 2022 approval letter noted, ““For Components 3 and 4, CMS also appreciates that the state incorporated changes to the payment arrangement to ensure that only facilities that maintain or improve performance on the identified metrics will receive payments under these components. If the state continues this payment arrangement for the SFY 2023 rating period or any future rating periods, CMS expects that such safeguards are maintained to continue ensuring that payments under any component conditioned upon performance only go to those facilities and providers that maintain or improve performance from one period to the next and not to providers that show declines in performance.”

- i. Can the state please confirm that for SFY 2023, payments will continue to be made only to facilities that maintain or improve performance on the identified metrics?

State Response: Yes, the State confirms that for SFY 2023, payments will continue to be made only to facilities that maintain or improve performance.

CMS Response (5/11/22): Please update Attachment C, Table 1 under Performance Target for Component 3 (Metrics 1-4) and Component 4 (Quarter 4 metrics) to add the following language, “ Any metric will be considered “Not Met” for the quarter/year if a NF performs worse than its initial baseline by more than this margin. Each metric’s margin will be defined as the absolute +/- change in the national average for that metric from the previous program year to the current program year.”

State Round 2 Response: Pre-print Attachment C, Table 1 Performance Targets and Notes have been updated and clarified accordingly.

- ii. Can the state please provide an update on the implementation of the new Component 3 and 4 performance requirements with the nursing facilities in the SFY 2022 rating period? Are there any performance results that the state can

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share with CMS for SFY 2022, perhaps for measures that are assessed on a quarterly basis?

State Response: MDS measures for Component 4 are not calculated until October 2022, after Q4. The table below relays how many of the 909 facilities eligible for Component 3 met respective MDS-based quality measures. These results are as of April 2022 and reflect Q1 and Q2.

SFY 2022 Reporting Period	Pressure Ulcers (NHC 453)	Antipsychotic Medications (NHC 419)	Independent Mobility (NHC 451)	UTIs (NHC 407)
Q1	587	472	778	708
Q2	555	517	732	721

CMS Response (5/11/22): How many of the facilities eligible for Component 3 did not earn payment because their performance was below the national baseline and failed to show improvement from their own baselines? How many of the facilities did not earn payment because their performance was above the national baseline but they did not maintain or improve their performance from their own baseline?

State Round 2 Response:

The following numbers of facilities did not earn payments because their performance was worse than the national average and they did not improve upon their baseline enough to meet the quarterly target:

SFY 2022 Reporting Period	Pressure Ulcers (NHC 453)	Antipsychotic Medications (NHC 419)	Independent Mobility (NHC 451)	UTIs (NHC 407)
Q1	224	186	100	106
Q2	262	199	142	110

The following numbers of facilities did not earn payments because their performance was better than the national benchmark but not within the allowed margin of decline from their baseline:

SFY 2022 Reporting Period	Pressure Ulcers (NHC 453)	Antipsychotic Medications (NHC 419)	Independent Mobility (NHC 451)	UTIs (NHC 407)
Q1	81	242	13	86
Q2	74	181	11	66

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Note that some facilities did not have sufficient data to calculate a result and do not appear in these counts.

CMS Response (6/3/22): The chart below attempts to capture the total number of facilities per quarter that did not receive payment per measure. It appears that facilities were most challenged by the NHC 453 and NHC 419 measures. Is this consistent with the state's historical tracking of performance?

SFY 2022 Reporting Period	Pressure Ulcers (NHC 453)	Antipsychotic Medications (NHC 419)	Independent Mobility (NHC 451)	UTIs (NHC 407)
Q1	81+224=305	242+186=428	13+100=113	86+106=192
Q2	74+262=336	181+199=380	11+142=153	66+110=176

State Round 3 Response:

The data here are preliminary. The State will defer inferences about historical trends until the three most recent quarters of data are available.

- b. The state's response to question 13 in Attachment C only refers to SFY 2022, there is no mention of SFY 2023. Please update this response for SFY 2023.

State Response: Thank you. Pre-print Attachment C has been revised to reflect this correction.

- c. How many facilities that are eligible for payment under Component 2 already meet the requirement to maintain 4 additional hours for 90% of days in the month? How many meet the requirement to maintain 8 additional hours for 90% of days in the month? As part of the SFY 2022 review, the state informed CMS, "As of March, SFY2021, 865 facilities were eligible for Component 2. Of those, 758 met the requirement to maintain 4 additional hours for 90% of days in the month, and 737 met the requirement to maintain 8 additional hours for 90% of days in the month."

State Response: In February of SFY 2022, 909 facilities were eligible for Component 2. Of those, 771 to meeting the requirement to maintain 4 additional hours for 90% of days in the month, and 749 to meeting the requirement to maintain 8 additional hours for 90% of days in the month.

CMS Response (5/11/22): CMS has summarized the information presented above in the chart below. Is this summary accurate and does state have any hypotheses as to why the decline in performance from SFY 2021 to SFY 2022?

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	As of March of SFY 2021 (865 eligible facilities)	As of Feb of SFY 2022 (909 eligible facilities)
Maintain 4 additional hours for 90% of days in the month	758/865 87.6%	771/909 84.8%
Maintain 8 additional hours for 90% of days in the month	737/865 85.2%	749/909 82.4%

State Round 2 Response: This summary is accurate. The State cannot confirm a meaningful decline in performance until SFY 2022 interim evaluation results are available.

- d. How many facilities that are eligible for payment under Component 4 already perform above the national average on each of the measures included in Component 4? As part of the SFY 2022 review, the state indicated, "As of the beginning of SFY2021, 547 facilities were eligible for Component 4: 430 facilities performed above the national average on (CMS N024.01) percent of residents with a urinary tract infection. As of Quarter 2, SFY2021, 547 facilities were eligible for the self-reported pneumococcal vaccine measure: 506 facilities performed above the national average."

State Response: As of the beginning of SFY2022, 604 facilities were eligible for Component 4. Of those, 538 were performing better than the national average on the pneumococcal vaccination measure (Nursing Home Compare ID 415), and 485 were performing better than the national average on the seasonal influenza vaccination measure (NHC ID 454).

As of the beginning of SFY2022, 909 facilities were eligible to earn funds related to the urinary tract infection measure (NHC ID 407) in Component 3. Of those, 710 began the year performing better than the national average.

CMS Response (5/11/22): CMS has summarized the information presented above in the chart below. Is this summary accurate and are there any considerations that the state would point out as it relates to these performance results?

	Beginning of SFY 2021	Beginning of SFY 2022
Urinary tract infection measure	430/547 78.6%	710/909 78.1%
Pneumococcal vaccine measure	506/547 92.5%	538/604 89.1%
Seasonal influenza vaccination measure	(was not implemented in SFY 2021)	485/604 80.3%

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State Round 2 Response: This summary is accurate. These are performance baselines, set at the beginning of the program year, and not performance results.

- e. How many facilities that are eligible for payment under Component 4 already have an active infection control program that includes pursuing improved outcomes in antibiotic stewardship? As part of the SFY 2022 review, the state indicated, “As of Quarter 2, SFY2021, 547 facilities were eligible for Component 4. Of those, 526 met the requirements for an active infection control plan.”

State Response: As of the beginning of SFY 2022, 604 facilities were eligible for Component 4. Of those, 581 facilities met Component 4 infection control requirements in Quarter 1, and 515 facilities met Component 4 infection control requirements in Quarter 2.

CMS Response (5/11/22): CMS has summarized the information presented above in the chart below. Is this summary accurate and are there any considerations that the state would point out as it relates to these performance results, including the decline in performance from quarter 1 to quarter 2 of SFY 2022?

	As of Quarter 2 of SFY 2021	As of Quarter 1 of SFY 2022	As of Quarter 2 of SFY 2022
Met the requirements for an active infection control plan	526/547 (96.2%)	581/604 (96.2%)	515/604 (85.3%)

State Round 2 Response: The summary is accurate. The Quality Metrics cannot be compared across SFY 2021 and SFY 2022, as the metrics have changed in SFY 2022. In SFY 2022, performance requirements vary from quarter to quarter and cannot be compared.

- f. The state has told CMS in prior QIPP preprint reviews that for Components 2 and 4, the state does a quarterly validation of the quality metrics on a representative sample of providers, and if the provider does not provide the supporting documentation or participate in the review, the state will recoup the pertinent funds. While the validation efforts were paused for COVID-19, will the state continue the efforts in SFY23?

State Response: Yes, the state plans to perform validation in SFY 2023.

- 7. The state also indicated in previous year reviews that it would recoup funds based on validation efforts. Can the state please denote if any funds were recouped in prior years for Components 2 and 4?

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State Response: At this time, the state has not recouped any funds from facilities identified for review during validation efforts.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

8. Preprint Question 19b: CMS asks the state to provide the increase on a per claim basis.

State Response: QIPP Component One represents an estimated uniform rate increase of \$44.11 per day/claim paid during the program period.

CMS Response (5/11/22): Could the state please clarify if the magnitude of the increase provided is subject to change after the reconciliation?

State Round 2 Response: The increase will change following the reconciliation if the actual utilization is different than the historical utilization used to calculate payments.

CMS Response 7/5/22: Can the state please update the preprint question 19.b to indicate that the estimated uniform rate increase is \$44.11 per day/claim paid.

State Round 4 Response: Preprint question 19.b has been updated to reflect the per day increase.

9. Preprint Question 19c:

- a. For Component 1, please further explain the reconciliation process, including what amount the state will be targeting for the retroactive reconciliation.

State Response: The SFY 2021 reconciliation is based on a methodology utilizing an 18 percent threshold. The difference between actual utilization and historical utilization used to determine payments was 17.30%. As a result, the reconciliation was not triggered, and the payments received by facilities during the program period were not adjusted. The SFY 2023 reconciliation is expected to occur within 120 days following the end of the program period. This reconciliation will be absolute to actual utilization during the program period, and there is no target to trigger the reconciliation.

CMS Response (5/11/22): This response mirrors the response provided to question 9.b below. Can the state please revisit this question, including what amount the state would be targeting during the retroactive reconciliation.

State Round 2 Response: The state will query paid claims within the billing system for the program period. The actual utilization will be used to determine the revenue each participating facility is eligible to receive for the component and the difference will be adjusted against the payments received by the facility. The reconciliation will occur, as there is no target that will trigger the reconciliation. The total amount paid through component 1 will not change, but the distribution amongst providers will change based upon actual billed claims at the time of the reconciliation.

CMS Response (6/3/22): The state indicates above that the “total amount paid through component 1 will not change”. This conflicts with what we previously understood in that the state intends to maintain the size of Component 1 as a percentage of the overall program value; however, the gross value of Component 1 could change if the overall

program value fluctuates as a result of caseload changes from the estimated value. Can the state please clarify?

State Round 3 Response: The total gross value of Component 1 is established prior to the program period using historic Medicaid utilization. The net value of Component 1 varies based on caseload during the program period and may fluctuate if actual caseload varies from forecasted caseload. The reconciliation to actual Medicaid utilization is a redistribution of the net value of Component 1 and will not impact the amount of total payments for Component 1 during the program period.

- b. Can the state provide any update on Component 1 reconciliations for the SFY 2021 and SFY 2022 rating periods?

State Response: The SFY 2021 reconciliation is based on a methodology utilizing an 18 percent threshold. The difference between actual utilization and historical utilization used to determine payments was 17.30%. As a result, the reconciliation was not triggered, and the payments received by facilities during the program period were not adjusted. The SFY 2022 reconciliation is expected to occur within 120 days following the end of the program period. This reconciliation will be absolute to actual utilization during the program period and there is no target to trigger the reconciliation.

10. Has the state made any progress in plans for incorporating performance measures into Component 1?

State Response: Component 1 has been designated a uniform percent increase and does not currently include any performance measures. Similar to SFY22, in SFY23, as a Condition of Participation requirement, NFs must conduct monthly QAPI meetings and report progress updates on their PIP. PIPs are not a quality metric with associated performance standards.

Reporting on the PIP is a process measure of quality-- facilities demonstrate adoption of evidence-based practices by conducting PIPs to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on the type of facility and the unique scope of services they provide. NFs will be submitting semi-annual PIP updates in SFY2023. A NF that fails to submit reports on progress in the PIP will be subject to remediation. Failure to respond will result in removal from the program and all funds earned may be recouped.

CMS Response (5/11/22): Thank you for this information. We note that the PIP is focused on a CMS long-stay MDS quality measure. Has the state considered tying some portion of the Component 1 payment to provider performance on this measure?

State Round 2 Response: As Component 1 has been designated a uniform percent increase, the State is not currently considering tying a portion of payments to performance measures.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

11. Preprint Question 21: The response to question 21 indicates that funds that are not earned will be distributed across all QIPP NFs that earned funds.

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- a. Can the state please explain what effect this is expected to have on the final reimbursement rate analysis for each class?
State Response: The state does not expect non-dispersed revenue to deviate drastically from previous enrollment periods. Non-dispersed funds accounted for 4.73% of revenue received during the SFY 2021 program period.
- b. In prior preprint reviews for QIPP, the state has provided CMS data demonstrating the portion of total lapse funds that have been allocated to each component based on actual experience for prior years of this payment arrangement. Would the state be able to provide this data for QIPP Year 4?
State Response: Please see the table below.

QIPP Year 4 Payment Summary					
	Component 1	Component 2	Component 3	Component 4	Total
Fund amounts used for capitation calculations	\$435,078,867	\$132,932,874	\$310,176,705	\$174,818,229	\$1,053,006,675
Available funds by caseload	\$388,410,905	\$118,674,065	\$276,906,152	\$156,066,662	\$940,057,784
Funds earned (per capitation rate, actual caseload, and met metrics) - Does not include Non-Disbursed Funds	\$393,104,067	\$103,133,842	\$250,409,809	\$147,769,411	\$894,417,128
Non-Disbursed funds	(\$4,693,162)	\$15,540,223	\$26,496,343	\$8,297,251	\$45,640,655
Earned Funds Percent	101.21%	86.91%	90.43%	94.68%	93.31%

12. Preprint Question 23:

- a. In previous years, the state had a minimum fee schedule requirement for nursing facility services tied to the state plan rate. While such a preprint is no longer subject to written prior approval, can the state confirm if this minimum fee schedule requirement would still be in effect for SFY 2023?
State Response: The state confirms that it requires plans to pay state plan approved rates for SFY 2023.
- b. Please clarify the approach and data provided in Table 2.
- It is unclear why the "Average Base Payment Level from Plans to Providers (absent the SDP)" column is at 0%?
State Response: The state directs plans to pay the state plan approved rates. The state's interpretation of the column "Average Base Payment Levels from Plans to Providers (absent the SDP)" is that all plan-based payments are state directed, therefore the state plan approved rates paid by plans is annotated in the column "Effect on Total Payment Levels of Other SDPs".

CMS Response (5/11/22):

- a. Thank you for this explanation. Our understanding is that that the other state directed payment is a minimum fee schedule set at the state plan rates – meaning that the state is setting a payment floor, but not instructing the plans to pay an exact rate. Is this correct? If so, we request that the state reflect what in actuality is the average base payment that the managed care plans pay in the “Average Base Payment Level”, knowing that managed care plans could pay more on average than the state plan rate.

State Round 2 Response: Your understanding is correct. The state response has been updated in the table below.

CMS Response (6/3/22): Thank you for the updates in the table below.

1. Can the state please submit a revised preprint to reflect in Table 2 of the preprint the revised data in the table below?

State Round 3 Response: The state preprint for question 23 has been updated.

2. In the first table, the average base payment and total reimbursement level for SFY 2023 is a considerably higher percent of Medicare than in previous years, particularly for the private nursing facilities. Can the state please discuss any potential factors behind this?

State Round 3 Response: The SFY 2023 average Medicaid reimbursement levels include an additional, temporary COVID rate add-on of \$19.63 per resident day paid to Texas nursing facilities during the PHE to account for increased associated with maintaining health and safety (additional PPE, staffing, etc.). The increase in Medicaid funding increased the Medicaid reimbursement as a percent of Medicare.

3. In the second table, could the state please discuss what may be driving the changes in the Percent of Commercial for SFY 2023 compared to prior years? It appears that there is significant variation from year to year for NSGOs (72.01%, 87.40% and 61.66%) and there was a significant decrease for private facilities for SFY 2023 (65.30%) versus prior years (89.40% and 93.64%).

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State Round 3 Response: The 2023 average commercial rates for private insurance clients in Medicaid contracted beds increased by approximately 75% as a result of changing economic conditions and a more recent data set. The average commercial rate reported for SFY22 was based on the 2018 NF CR at a rate of \$271.41 for all facilities. The SFY23 rate is based on the 2020 NF CR and increased to \$473.87.

- b. CMS has pulled the analysis provided as part of the SFY 2022 review and added columns for the SFY 2023 review. Can the state please update this table for SFY 2023?

	SFY 2023		SFY 2022		SFY 2021	
	Average Base Reimbursement Level (as % of Medicare)	Total Reimbursement Level (as % of Medicare)	Average Base Reimbursement Level (as % of Medicare)	Total Reimbursement Level (as % of Medicare)	Average Base Reimbursement Level (as % of Medicare)	Total Reimbursement Level (as % of Medicare)
NSGO	69.81%	90.76%	45.62%	79.46%	45.61%	82.04%
PRIVATE	82.40%	88.96%	47.13%	55.21%	47.36%	55.46%

	SFY 2023		SFY 2022		SFY 2021	
	Percent of Medicare	Percent of Commercial	Percent of Medicare	Percent of Commercial	Percent of Medicare	Percent of Commercial
NSGO	90.76%	72.01%	79.46%	87.40%	82.04%	61.66%
PRIVATE	88.96%	65.30%	55.21%	89.40%	55.46%	93.64%
Grand Total	93.73%	71.36%	65.88%	88.33%	67.09%	73.31%

- c. The state provided the following descriptions for each of the columns above as part of the SFY 2022 review. Please confirm that these descriptions remain the same for the SFY 2023 analysis that CMS is requesting.
- Average Base Reimbursement Level (as % of Medicare): Equals Medicaid Daily Base (As calculated in UPL Demo) divided by Medicare Daily Base (As calculated in UPL Demo)
 - Total Reimbursement Level (as % of Medicare): Equals the total Medicaid Rate with QIPP included divided by the Medicare Daily Base (As calculated in UPL Demo)
 - Percent of Medicare: Equals the total Medicaid Rate with QIPP included divided by the Medicare Daily Base (As calculated in UPL Demo)

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- Percent of Commercial: Equals the total Medicaid Rate, with QIPP included, divided by the Commercial Daily Base (As calculated in UPL Demo)

State Round 2 Response: The state affirms the descriptions in bullets #1-4 above for SFY 2023. The Percent of Commercial description in bullet #4 is derived from the 2020 Nursing Facility Cost Report.

CMS Response (6/3/22): Thank you for affirming. Is the 2020 Nursing Facility Cost Report a new data source for SFY 2023? And is this report specific to Texas nursing facilities?

State Round 3 Response: Nursing Facilities providing Medicaid services in Texas submit cost reports on a biennial basis for even-numbered years. Once the cost reports are submitted, HHSC conducts a financial examination pursuant to Texas Administrative Code §§355.101-.105. The most current financially examined cost report data is the 2020 Nursing Facility cost reports. The statistical and expense information from the 2020 Nursing Facility cost reports will be utilized for the SFY2023 and SFY2024 program periods.

- ii. Additionally, can the state please explain why 2021 QIPP payments were used for the Table 2 analysis? Could the state use proposed SFY 2023 QIPP payments?

State Response: The SFY 2021 payments were used as an estimate for table 2 as the most recently available data for Medicare comparison. QIPP is a voluntary program and details regarding the provider classes for SFY 2023 cannot be accurately determined until the end of the enrollment period. Processing of enrollment is estimated to be completed in late April 2022.

CMS Response (5/11/22): The analysis provided for the SFY 2022 QIPP review accounted for the facilities that had enrolled for SFY 2022. We request that the state take a similar approach for SFY 2023 and account for the number of facilities enrolled for SFY 2023 and any other changes that should be accounted for as part of the SFY 2023 rating period.

State Round 2 Response: The state has updated the calculation, and the SFY 2023 Medicaid days are accounted for in the responses to question 12 above.

CMS Response (6/3/22): Thank you. Can the state please update the response to preprint question 27 and resubmit the preprint?

State Round 3 Response: The state preprint for question 27 has been updated.

CMS Response 7/5/22: The response to preprint question 27 does not describe how the state used SFY 2023 Medicaid days as part of the calculation. Please clarify and revise the question 27 response.

State Round 4 Response: The state has updated the preprint question 27 to provide additional detail requested. The state has also made a minor correction to question 23, table 2, as the formatting for Table 2 caused one figure to display incorrectly previously.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

13. 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 in Component 1.

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): Could the state's actuary please 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 +/- 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.

14. 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 0.125% for administration, 1.75% for 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.

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15. 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 component 1, after accounting for MCO fees detailed in question 14.

SECTION IV: FUNDING FOR THE NON-FEDERAL SHARE

Summary: The financing of the state directed payments made under the QIPP program appear to be financed by local units of government providing intergovernmental transfers (IGTs) funds that are largely derived from the taxing authority of these units of government through the Local Provider Participation Fund, or LPPF. 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.

State Response: The state wishes to clarify to CMS that LPPF-derived funds are not currently used a source of local funding for QIPP.

16. Similar to the CHIRP spreadsheet, there appears indications that Coryell County Memorial, Decatur, Fannin County, and Uvalde County Hospital Authorities all have taxing authority, while the QIPP spreadsheet indicates that they do not have taxing authority. Please explain this discrepancy.

State Response: HHSC identified the apparent discrepancy was due to a formatting and sorting issue. with the CHIRP Attachment F. An updated attachment will be provided with the CHIRP Response.

17. Related to the above, for any entities that may or may not have taxing authorities and do not receive any state appropriated funds, please describe how the funding for those IGTs is derived. We note that in some of the funding information provided under the various proposals, that some of the entities which do not have taxing authority and do not receive payments are funding a substantial IGT (\$20M or more). 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 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

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appropriations, commercial patient revenue where the entity is a service provider, or other available public funds.

18. The proposed funding for QIPP appears to remain largely unchanged from the prior iteration to the more recent proposal. What, if anything, has changed on the QIPP financing?

State Response: The proposed funding for QIPP SFY 2023 remains unchanged from the previous program period.

19. Likewise, we note in one of the attachments (“Attachment F-1 QIPP 5 Year Eligible NSGO Providers.xls”) which seems to indicate that there is a significant ownership transfer component to the QIPP, where private nursing facilities transfer the ownership of their facility to units of government in order to be considered Non-State Government Owned providers.

- a. Can the state provide a sample of one of the ownership/lease agreements between the private entity and the non-state government entity, if such agreements exist?
- b. Do the private owners of the nursing facilities retain management, operations, and licensing responsibilities of the nursing facility?
- c. Are the non-state government owners required to pass funds down to the private operators under an agreement, and likewise, are any of the supplemental payment funds held for future use as an IGT in any circumstance?

State Response: Ownership of Medicaid contracted facilities is a business decision for each facility contracted to deliver client care. The circumstances and information used to determine a potential change in ownership is proprietary, and the state does not have access to considerations made by facilities. When a non-state government owns a nursing facility, they are the owner of record and assume all legal responsibilities, including benefits and liabilities, as the license holder and enrolled Medicaid provider. The state does not direct or require any Medicaid provider, including NSGO’s that own nursing facilities, to utilize their Medicaid revenues in any particular manner. The state is similarly not a party to any management or operational contracts an owner might have with a management entity as the state’s contractual Medicaid relationship is exclusively with the enrolled Medicaid provider.

That said, 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. As noted above, the Provider Finance Department, through the Local Funds Monitoring team, will provide oversight through 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](#). This oversight mechanism will include review of agreements between a local governmental entity and a private provider. To the extent such agreements exist establishing the ownership structure described above, HHSC will ensure that funds transferred as the non-federal share are eligible public funds, and are not derived through the use of federal funds in the manner described in sub-question c, above. 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.

CMS Response (5/11/22): Regarding question #19 of the state’s Round 1 responses, can the state provide an analysis of nursing facility ownership starting on 01/01/2017 and for all years

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that include the State Directed Payments (SDP)? Specifically provide an analysis on changes from private to non-state government ownership and the dates for which they occurred. CMS can now point the state to a change of ownership resource published by CMS: <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/skilled-nursing-facility-change-of-ownership> For reference, CMS staff reviewed a number of facilities that are said to be owned by the City of Ennis, Texas.

State Round 2 Response: Please see Attachment H which is a summary of the listed ownership type for each QIPP enrolled facility by program year. HHSC does wish to remind CMS that there has been significant volatility in providing long-term care services over the past several years with the combination of the public health emergency resulting from COVID-19, the bankruptcy of a large chain of nursing facilities, and other factors. While the state can provide the information about changes in ownership type, the state is not able to provide CMS any information that would indicate the underlying reasoning for business decisions made by the owners of nursing facilities.

- a. In reviewing some of the facilities and the cities/counties/entities listed as owners, it seems like there may be some facilities that have changed ownership in name only. Some of the facilities themselves still represent themselves as privately owned, for-profit corporations on their own websites. Has the state done any analysis regarding the legitimacy of the ownership transfers that have occurred which make providers eligible for these payments? What steps is the state willing to take to ensure that payments intended for non-state government owned or operated facilities go to legitimate non-state government owned or operated facilities?

State Round 2 Response: HHSC's Medicaid program has not examined the ownership transfers that have occurred, as an examination and approval of a change of ownership is conducted by the state's regulatory oversight division. In obtaining the ownership (and license), the non-state government entity assumes all legal responsibility for the facility and is the "legitimate" owner.

HHSC requires a non-state government owned facility that applies to participate in QIPP to certify the following:

- That it is a non-state government-owned NF where a non-state governmental entity holds the license and is party to the facility's Medicaid contract; and
- That all funds transferred to HHSC via an intergovernmental transfer (IGT) for use as the state share of payments are public funds.
- That the NF is located in the state of Texas in the same RHP as, or within 150 miles of, the non-state governmental entity taking ownership of the facility, was owned by the non-state governmental entity for no less than four years prior to the first day of the program period, or is able to certify in connection with the enrollment application that they can demonstrate an active partnership between the NF and the non-state governmental entity that owns the NF. The following criteria demonstrate an active partnership between the NF and the non-state governmental entity that owns the NF.

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- Monthly meetings (in-person or virtual) with NF administrative staff to review the NF's clinical and quality operations and identify areas for improvement. Meetings should include patient observations; regulatory findings; review of CASPER reports, quality measures, grievances, staffing, risk, incidents, accidents, and infection control measures; root cause analysis, if applicable; and design of performance improvement plans.
- Quarterly joint trainings on topics and trends in nursing home care best practices or on needed areas of improvement.
- Annual, on-site inspections of the NF by a non-state governmental entity-sponsored Quality Assurance team.

b. In other instances, the owner listed on the CHOW database are located a considerable distance from the facility that they own. To the extent that the state is aware, please indicate what benefit it would provide for a city government to own a facility that is between 130-270 miles away. We are concerned that the incentive to own a facility so geographically distant from the owner is purely based on access to increases in federal funding, and not based on actual transfers of ownership or changes in patient experience. Has the state provided any guidance to cities/counties/hospital districts as to ensuring that the integrity of the non-federal of the Medicaid payment and ensuring that there is no recycling occurring between owners and operators of the facilities?

State Round 2 Response: As CMS is aware, Texas is a large state and mileage may not be an indication that a unit of government's interests are not served by ownership of a facility. In Texas, there may be circumstances where patients seek care a considerable distance from their original place of residence, and a governmental entity may have an appropriate and reasonable interest in ensuring access to long-term care services outside of their own jurisdiction. Texas' Medicaid program does not examine the underlying decision-making that might result in a unit of local government choosing to own a nursing facility but has made the decision to only allow NSGO participants in QIPP who are not only publicly-owned, but are also able to demonstrate certain criteria as described above. HHSC has not provided specific guidance to QIPP-participating nursing facility owners or the management companies they may employ related to IGT. However, 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 nursing facility providers and other such 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

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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. CMS has found in the past that instances where there are numerous changes in provider ownership from private to, either state government or non-state government ownership, additional scrutiny may be necessary when new supplemental payments funded by IGTs are introduced. 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 the specific sources of funds 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: HHSC appreciates CMS's feedback regarding the state's ongoing monitoring efforts.

CMS Response 7/5/22: 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 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.

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

State Response: At the original time of preprint submission, HHSC had not sent suggestion 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.

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

State Response: 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. 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.

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22. Recent OIG report (Report No. [A-06-18-07001](#)), found that the state was funding large portions of the IGTs under QIPP using loans and other debt instruments. Note that 1903(w)(6)(A) of the Act provides that “the Secretary may not restrict States’ use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.” However, loans and debt instruments are not “State or local taxes” and under 42 CFR 433.51 such loans or debt instruments would not be considered, “under [the unit of government]’s administrative control” so long as they are borrowed and owed back to another entity. We have concerns that such funding mechanisms constitute recycling and/or reassignment of provider payments under, 42 CFR 447.10, as the total computable payment, owed to the provider would always need to repay the loan taken out on that provider’s behalf by the unit of government, therefore the “payments” under the state plan would never be made, in full, to the nursing facility providers. Please describe how the payments proposed under the QIPP in this most recent proposal addresses these concerns.

State Response: As noted in prior responses, 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. QIPP payments to providers comply with § 447.10 and the reimbursement structure approved by CMS.

As HHSC noted in its response to the draft audit report, the language of § 433.51 does not support DHHS-OIG’s position. On the contrary, the plain language of the regulation permits the state to accept loan funds as the non-federal share. The loan funds transferred from the governmental entities were public funds because they were in the hands of the local governmental entity when they were transferred to HHSC.

Moreover, DHHS-OIG’s position is inconsistent with the Social Security Act. Section 1903(w)(6) of the Social Security Act says that “the Secretary may not restrict States’ use of funds where such funds are derived from State or local taxes,” unless funds transferred from units of government are impermissible donations or taxes. The statute does not limit “public funds” to tax-generated and appropriated funds. Rather, that section of the Act prevents CMS from restricting the states’ use of funds derived from certain sources. It does not address public funds derived from other revenue sources, or imply that other revenue sources, such as loans, are not eligible public funds to be used as the non-federal share.

HHSC disagrees that IGT funds must be under the administrative control of the transferring unit of government. HHSC noted in its response to the DHHS-OIG QIPP audit that the IGT funds at issue were under HHSC’s control, as required by 42 C.F.R. 433.51(b). CMS did not contest this interpretation in its response to the report.

As noted above, all local funds are being phased into the Local Funds Monitoring oversight process, as described in the proposed rule available [here](#). This oversight mechanism will include review of agreements between a local governmental entity and a private provider and bond or

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other debt instrument documentation to the extent such agreements or instruments impact the funds transferred for use as the non-federal share. HHSC's ultimate goal in the implementation of this expanded oversight is to ensure that funds transferred as the non-federal share are eligible public funds, and HHSC remains committed to ensuring that local 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, public revenue instruments, such as bonds, commercial patient revenue where the entity is a service provider, or other available public funds. 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.

CMS Response (5/11/22): MS Response (5/11/22): Regarding the response to question #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?

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 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: HHSC appreciates CMS's feedback regarding the state's ongoing monitoring efforts.

23. 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.

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24. The QIPP spreadsheet indicates that there is an “8% holdback” on the IGT. Can the state address what that represents or what costs it covers, how it is calculated, and whether or not the state claims FFP for that holdback? Please describe, in detail, how the holdback is used, where the funds go once they are held back, and which entities receive this funding.
State Response: The state collects an additional 8% on IGT to account for fluctuations between forecasted member months and actual utilization within the program period. Actual IGT expended during the program period is reconciled within 120 days following the end of the program period. The state holds 2% of the IGT collected following the reconciliation through the runout period to account for changes in member months. Any surplus in IGT collected for the program period is refunded to the local governmental entity that provided the IGT. Any surplus IGT remaining following the runout period is refunded to each local governmental entity in the same manner.
25. 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](#).
26. During the SFY 2022 preprint reviews, it was noted that the state had proposed to use bonds or other such debt instruments to assist in funding the non-federal share of the Medicaid payments proposed in some of the pre-prints. Does that continue to be the case in these pre-print proposals or has the state changed the manner in which the payments proposed in SFY 2023 are funded?
State Response: The state has not changed the manner in which the payments proposed in 2023 are funded.
27. In “Attachment F – Table 4 IGT Transferring Entities” - 68 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

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authority, state appropriation, county appropriation, etc. depending on their individual enabling statutes.

28. Similar to the SFY 2022 submission for QIPP, we note the following:

As affirmed in response to question 14 [of the SFY 2023 submission], it is the state's responsibility to ensure that funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51. The ability of a unit of government to issue bonds is typically defined by the government entity's authorizing statute. We are assuming that this is the case with the hospital districts involved in this arrangement. The statute indicates that CMS "may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section." To the extent that bonds are neither state or local taxes, the state has an obligation to ensure that the transferred funds are not "derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share" as indicated in the statute. Please note, that CMS is researching this matter further and may have additional questions for the state.

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 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](#). 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.

- a. CMS has concerns that to the extent that the providers or provider-related organizations are participating in the purchasing of municipal bonds, that such participation could provide the appearance of a provider-related donation, potentially requiring the state to offset the collected value of the donation from the claim for FFP. Further, the notion that bonds can be thought of as loans that investors make to local governments, then the repayment of the bonds to any provider or provider-related organization may provide the appearance of recycling. The state is obligated to ensure these funding mechanisms are consistent with the statute and implementing regulations throughout the operations of such payment programs. Has the state considered how it intends to oversee the sources of financing that will support payments under this

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proposal to ensure the arrangements do not now and in the future entail non-bona fide provider related donations or recycling of federal funds?

State Response: HHSC is not aware of any circumstances in which a provider or provider-related organization has participated in the purchasing of municipal bonds. 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.

- b. Please affirm the understanding that approval of this funding mechanism by CMS to serve as the non-federal share would not protect the state from financial risk should the arrangements result in non-bona fide provider related donations or a recycling mechanism as our review is predicated on the issued bonds as a normal course of business and not as a means to circumvent federal financing requirements.

State Response: HHSC affirms this understanding.

SECTION V: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

29. Preprint Question 44: Thank you for submitting the evaluation metrics the state will use to evaluate this payment arrangement. During technical assistance calls with the state, CMCS and the state discussed limiting the MDS data used to calculate the evaluation metrics to Medicaid managed care enrollees. However, we noticed that the evaluation plan appears to include all-payer data. Please provide an update on the state's plan to assess the impact of this payment arrangement specifically on Medicaid managed care enrollees receiving services under the payment arrangement.

State Response: During technical assistance calls, the state and CMS discussed limiting the MDS data used to calculate NF performance on long-stay quality metrics to Medicaid managed care enrollees only. However, the evaluation of how the program advances the goals and objectives of the State's quality strategy is based on benchmarks such as the national and state average, which are calculated and published by CMS and include all payer types. The state will discuss further developments of this methodology.

CMS Response (5/11/22): Thank you for this clarification. The state indicates in the response above that they will discuss further developments of this methodology. Will the state be providing a revised evaluation plan? Please note that CMS will require the provision of interim Year 5 evaluation findings with the SFY 2024 preprint submission.

State Round 2 Response: The State affirms the understanding that interim Year 5 evaluation findings will be included with the SFY 2024 preprint submission. At this time, the State has no further updates to the SFY 2023 evaluation plan methodology.

CMS Response 6/3/22: CMS is exploring options for how states can obtain evaluation data at the beneficiary level. We recognize that this will not be feasible for Texas to pursue for the SFY

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2023 rating period, but encourage the state to continue discussions with CMS for future QIPP submissions. CMS is happy to provide technical assistance.

State Round 3 Response: Thank you. The state is committed to continued discussions with CMS.