

## SECTION I: DATE AND TIMING INFORMATION

### 1. Preprint Question 4:

- a. Please clarify if the estimated total dollar amount provided in response to question 4 includes any allowance for administration, profit margin, or premium tax.

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

- b. Please provide estimates of the share of the total dollars provided in response to question 4 that is for:
  - i. Component 1 - \$7,957,751
  - ii. Component 2 - \$2,654,343
  - iii. Administration, profit margin, or premium tax. - \$652,084

- c. 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 (April 21, 2022):** At the time of preprint submission, the enrollment period for the RAPPS Program Fiscal Year 2023 had not yet ended. The proposed methodology for FY2023 is what is represented in Attachment C but will be updated when the calculation is complete.

## SECTION II: TYPE OF STATE DIRECTED PAYMENT

### 2. Preprint Question 8, Attachment B:

- a. Please affirm that the payments required under this payment arrangement will **only** be made for Medicaid services on behalf of Medicaid beneficiaries covered under the Medicaid managed care contract for the SFY 2023 rating period **only**, and that the payments will not be made on behalf of individuals who are uninsured, covered for such services by another insurer (e.g. Medicare), nor Medicaid services provided through the state's fee-for-service program?

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

- b. Attachment B says:
  - i. "Payments will be based on units using each provider's utilization during the service period from March 1, 2019, to February 29, 2020." This was the timeframe used for SFY 2022. Should this be updated for the state's SFY 2023 submission?

**State Response (April 21, 2022):** No, the state plans to use the same time frame as a basis for the SFY2023 submission with different trends applied.

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

**State Response (April 21, 2022):** The annual reconciliation should say for “SFY2023 utilization”. Attachment B has been revised.

- c. As noted in the approval letter for the SFY 2022 RAPPS proposal, for the SFY 2023 rating period, payments for all components of the arrangement will need to be conditioned upon the delivery and utilization of covered services rendered to Medicaid beneficiaries during the SFY 2023 rating period. This means that for any part of the payment arrangement that bases payment on services rendered during a previous rating period, the requirement of a reconciliation threshold higher than zero percent will not be considered sufficient to meet this regulatory requirement.
  - i. Please provide a confirmation that no reconciliation threshold will be higher than zero percent for any TIPPS components for SFY2023.

**State Response (April 21, 2022):** The state confirms the reconciliation threshold will be zero percent for any RAPPS components for SFY2023. The state assumes this question is meant to reference RAPPS, not TIPPS.

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

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

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

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

- iv. The state indicated the following during the SFY 2022 review of TIPPS. Has any of this changed for SFY 2023 TIPPS 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 (April 21, 2022):** With respect to the first above statement, once HHSC completes the reconciliation of Component 1, the state's actuary will review the results and determine if RAPPS capitation rate changes are necessary to adhere to actuarial soundness requirements. The state affirms the second above statement for RAPPS and assumes that the question is meant to reference RAPPS, not TIPPS.

#### SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

3. Preprint Question 19b:

- a. The state indicates, "The enrollment has not begun for year 2, and there are no substantial changes to the program from year 1. New numbers will be provided when enrollment is complete." When will enrollment begin for Year 2 and when will it be completed?

**State Response (April 21, 2022):** Enrollment opened on March 2, 2022 and closed on March 29, 2022. Processing of enrollment is estimated to be completed in late April 2022.

- b. The state provides the same uniform dollar and percent increases that were provided in the SFY 2022 preprint review. When will the state know if these increase amounts will need to be revised?

**State Response (April 21, 2022):** The state estimates that a preliminary calculation will be made available by the end of April. CMS will be informed of possible revisions to the uniform dollar and percentages increases at that time.

- c. Can the state confirm, as was the case for SFY 2022, this state directed payment (both Components 1 and 2) would be paid in addition to the PPS rate required by 1902(bb) to be paid to Rural Health Clinics and not in place of any part of the required PPS rate?

**State Response (April 21, 2022):** The RAPPS payments will be made in addition to the PPS rate payment required by 1902(bb).

#### SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

4. Preprint Question 21:

- a. For SFY 2022, rural health clinics in Texas were required to submit an enrollment application by April 13, 2021 and there were 17 freestanding clinics and 154 hospital based clinics participating in the program. For SFY23, does the state know how many clinics, by provider class, will be participating?

**State Response (April 21, 2022):** Enrollment applications for the SFY23 rating period were due to the state by 11:59 PM on March 29th, 2022. No applications were accepted for RAPPS SFY 23 participation after this date. Data aggregation has not yet been completed, but the state will provide an update to CMS once analysis is complete.

- b. The state indicates, “In Component 1, payments will be based on the same unit increase for applicable procedure codes by RHC class, using each provider’s utilization during service period March 1, 2019 to February 29, 2020.” Please confirm that this is the time period that will be used for utilization.

**State Response (April 21, 2022):** Confirmed, the state will use the above referenced time frame for utilization.

5. Preprint Question 23: Can the state please confirm, as was the case for SFY 2022, that the RAPPS payments will be made in addition to the PPS payments, and that no wrap payment is made to the RHCs.

**State Response (April 21, 2022):** The RAPPS payments will be made in addition to the PPS rate payments. No wrap payment is paid to RHCs.

6. Preprint Question 25: The state has a minimum fee schedule requirement for rural hospital inpatient and outpatient services tied to the state plan rate. Can the state please confirm that there is no overlap between this state directed payment proposal and the rural hospital minimum fee schedule requirement?

**State Response (April 21, 2022):** The state confirms that there is no overlap between the hospital minimum fee schedule required under the state plan and the directed payments to rural health clinics.

#### SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

7. Will the state include TIPPS in the capitation rates in a manner consistent with prior years? If not, please describe the differences in the methodology this year.

**State Response (April 21, 2022):** Yes. The state assumes that the question is meant to reference RAPPS, not TIPPS.

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

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

- b. And does the state expect to amend the rates or rate certifications as a result of the reconciliation for SFY 2023?

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

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

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

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

**State Response (April 21, 2022):** Scorecards direct the MCOs to pay out the capitation received for component 1, , after accounting for MCO fees detailed in question 9.

#### SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

11. We note that are at least two entities receiving payments for which there is no taxing authority or state appropriations available at the provider. Please detail how funding for those particular entities is derived, whether it comes from a different unit of state or local government, bond or other debt instrument, or some other source.

**State Response (April 21, 2022):** 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.

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

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

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

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

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

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

**State Response (April 21, 2022):** There is no compulsory IGT requirement and there are no agreements requiring an IGT of any amount from a state or local governmental entity. Due to the voluntary nature of the IGT contribution, 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.

15. CMS understands that the state is in the process of setting up an oversight group related to the financing mechanisms described in this state directed payment preprint. Please describe steps in the near-term that the state will use to effectively oversee how these program payments are funded by the state or local units of governments.

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

16. During past preprint reviews, it was noted that the state had proposed to use bonds or other such debt instruments to assist in funding the non-federal share of the Medicaid payments proposed in some of the pre-prints. Does that continue to be the case in these pre-print proposals or has the state changed the manner in which the payments proposed in 2023 are funded?

**State Response (April 21, 2022):** 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.

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

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

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

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

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

**State Response (April 21, 2022):** Although HHSC has not yet received funds from local governmental entities that plan to contribute IGT to the RAPPS program, it is anticipated that some of the public funds will be generated using a locally administered health care-related provider tax, known in Texas as a Local Provider Participation Fund or LPPF.

The Provider Finance Department within HHSC has established a Local Funds Monitoring team that is responsible for collecting information from each local governmental entity that provides local funds as the non-federal share of Medicaid payments, including those that assess and collect local health care related provider taxes. 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](#). HHSC believes that Local Provider Participation Fund collections will be a minor portion of the public funds transferred for the RAPPS program.

The state understands and agrees that it is our responsibility to ensure that the non-federal share of funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51.

20. In “Attachment E – IGT Entities” - 113 entities are classified as “other” under operational nature. Please define the operational nature for each of these entities as most are not classified as typical IGT-eligible entities (i.e., state, county, city).

**State Response (April 21, 2022):** HHSC has provided a list for Attachment E – 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. Texas has several classes of local entities that are referred to as Hospital Authorities, Hospital Districts, Local Mental Health Authorities, and others that are generally contiguous with a specific county or city, but are a unique unit of local government; therefore, the county or city designation was not appropriate. Due to the limitation to County, City, or Other, we selected “Other” for these various entity types. These entities have been in place for many decades and, much like a county or city, are units of local government with varying sources of public funds, including taxing authority, state appropriation, county appropriation, etc. depending on their individual enabling statutes.

21. CMS continues to harbor serious concerns regarding the financing for the CHIRP, RAPPS, and TIPPS program that are financed by Local Provider Participation Fund health care-related taxes. Specifically, CMS is concerned that this method of financing contains a hold harmless arrangement as laid out at section 1903 (w)(4)(C) of the Act and implementing regulations at 42 CFR § 433.68 (f)(3). CMS has a non-discretionary obligation to reduce the state’s medical assistance expenditures by the amount of any health-care related taxes if such health care-related taxes have in effect a hold harmless arrangement. CMS has indicated that Texas could resolve those concerns either by providing the information requested by CMS to show that no such hold harmless arrangements exist or by showing that it is acting to end any such arrangements that are in place, including by issuing guidance to its providers that such practices constitute impermissible hold harmless arrangements. Can the state please confirm that its position on this issue has not changed?

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



SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

22. Thank you for providing a Year 2 Evaluation Plan for CHIRP, BHS, TIPPS and RAPPS. We understand from the Evaluation Plan that only BHS baseline data was available at the time of the SFY 2023 preprint submission. Our understanding from prior conversations with the state in November 2021 was that provider-reported data covering January-June 2021 would be available in February 2022 and full CY 2021 data would be available in May 2022.

- a. Can the state please provide an update as to when preliminary data from Jan-June 2021 will be available for CHIRP, RAPPS and TIPPS?

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

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

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

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

**State Response (April 21, 2022):** Yes, this is still the case. HHSC is set to receive preliminary data from the EQRO in August 2022 and final data from the EQRO in October 2022. As included in the response above, the final Year 1 Evaluation Report will be published no later than February 2023.

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

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