

Round 4 Question Set

July 8, 2022

SECTION I: DATE AND TIMING INFORMATION

1. Preprint Question 4:

- a. Could the state please confirm if the amount provided in response to question 4 includes provisions for non-benefit costs such as margin, administrative load, and/or taxes and fees? If so, could the state please 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.

CMS Response (5/11/22): Can the state please provide the amounts attributed to these non-benefit cost provisions?

State Round 2 Response: Per the updated Attachment C, the estimated fee total is \$303,634,362.

- b. Please describe why the amount provided in response to question 4 (i.e., \$4.7B) is the same estimate as what was provided in last year's preprint.

State Response: At the time of preprint submission, the enrollment period for the CHIRP Program Fiscal Year 2023 had not yet ended. The state could neither provide the list of enrolled hospitals, nor the applicable data used to calculate rate increases and estimated payments. The proposed methodology for FY2023 is what is represented in Attachment C but will be updated when the calculation is complete.

CMS Response (5/11/22): Is it still the case that the revised rate increases and estimated payments will be ready to share with CMS in late May or early June? CMS will need this information as part of our review of this SFY 2023 proposal.

State Round 2 Response: HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. HHSC will provide the final documents to CMS as soon as they are available. However, per our call on May 13, 2022, HHSC can provide our preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS' review. Please see updated preprint and attachments.

CMS Response (6/3/22):

1. For the SFY 2022 rating period, the state provided a total dollar estimate of \$4.7 billion for the CHIRP state directed payment. Based on available data to-date, can the state provide a revised accounting of what the actual spend has been to date for CHIRP for SFY 2022?

State Round 3 Response: As of May 31, 2022, total payments for the SFY2022 CHIRP directed payment program are approximately \$3 billion for the first six months of the program. Based on the total expenditures for the first six months, the estimated

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annualized total expenditure for SFY2022 will be \$5.9 billion. The estimated annualized total expenditure is subject to change.

CMS Response 7/8/22: Does the state have a revised estimated annualized total expenditure for SFY 2022 that can be shared with CMS?

State Round 4 Response: Annualized expenditures for SFY22 are estimated to be \$6,163,987,973, but the rating period will not conclude until August 31, 2022, so that total is subject to change.

2. For the SFY 2023 rating period, the state provides a total dollar estimate of \$5.2 billion. Can the state please discuss the reasoning behind the increase in the magnitude of the payment?

State Round 3 Response: The combination of the Medicare UPL gap and the ACR gap are the main contributors of the increase in magnitude of payment. Specifically, the total inpatient UPL gap increased by about \$450M from SFY2022 to SFY2023 for CHIRP participants. The total outpatient UPL gap decreased by about \$50M. The total ACR gap before accounting for UHRIP payments went up \$350M. Data will vary from year to year based on factors including participants, Medicaid data, ACR data, and Medicare data. For example, Texas Children's Hospital's Medicare payment to charge ratio increased from 38% to 65% from the 2021 Medicare UPL test (used in SFY2022 CHIRP) to the 2022 Medicare UPL test (used in SFY2023 CHIRP), resulting in an approximate increase in inpatient Medicare gap of \$280M.

CMS Response 7/8/22: The preprint submission dated June 22, 2022 contained a total dollar estimate of \$5,230,952,997. The preprint submission dated June 30, 2022 that accounted for the outlier analysis has a total dollar estimate of \$5,240,195,505. The state notes in the CHIRP Change Log template that the difference in total dollar estimate is based on updated self-submitted ACR data for Hendrick Abilene, Rusk State Hospital, Clarity Childrens, Haskell, Heart of Texas, and Kimble. In addition, the previous encounter estimates are now final. Can the state please confirm that \$5.240B is the final total dollar amount and if not, please update the preprint reflect the correct amount.

State Round 4 Response: The state affirms the \$5.240B as the estimated program total.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

2. CMS previously communicated the concern that this payment arrangement could create perverse incentives for the plans. For example, the required uniform increases could result in plans negotiating lower base rates with providers subject to the state directed payment. For the SFY 2023 rating period, has the state instituted any new measures to counteract such perverse incentives?

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State Response: The state has not instituted any new measures to this effect but is prepared to do so.

3. Has the state made any changes to its approach to monitoring that the plans are complying with the contract provisions to pay these uniform increases?

State Response: Managed Care Plans are required to submit all claims with the CHIRP increase with a specified indicator for tracking. The plans are aware of the indicator requirement and the state has been communicating with the plans to emphasize the importance of this indicator since the summer of 2021.

4. Preprint Question 8:

- a. For SFY 2023, have there been any changes to the methodology used to calculate the UHRIP and ACIA payment increases?

State Response: There have been no changes from the SFY2022 approved methodology.

- b. 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: 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.

5. Preprint Question 19b (Attachment C):

- a. The "Q19b CHIRP Rate Increases" tab in Attachment C shows rate increases per claim by class that are identical to SFY 2022. Further, many tabs in Attachment C refer to "SFY 2022" in their titles. Can the state please confirm that the information submitted in Attachment C on March 1, 2022 is intended to represent the current SFY 2023 renewal preprint? If so, can the state please explain why the rate increases for SFY 2022 and SFY 2023 are expected to be identical?

State Response: At the time of preprint submission, the enrollment period for the CHIRP Program Fiscal Year 2023 had not yet ended. The state could neither provide the list of enrolled hospitals, nor the applicable data used to calculate rate increases and estimated payments. Currently, Attachment C is only representative of the methodology and will be updated with SFY 2023 information when that information is available.

CMS Response (5/11/22): Is it still the case that the revised rate increases and estimated payments will be ready to share with CMS in late May or early June? CMS will need this information as part of our review of this SFY 2023 proposal.

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State Round 2 Response: HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. HHSC will provide the final documents to CMS as soon as they are available. However, per our call on May 13, 2022, HHSC can provide our preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS' review. Please see updated preprint and attachments.

CMS Response (6/3/22): Thank you for providing preliminary rate increases and estimated payment data. In general, it would be helpful for the state to identify what data it expects will change with the final submission in June.

1. In looking at tab "CHIRP Payment Calc" in Attachment C, can the state please confirm the following statistics that we pulled?

a. Of the 408 enrolled hospitals in CHIRP for SFY 2023, 394 of them requested to participate in ACIA.

State Round 3 Response: There are now 407 enrolled providers, and 393 have requested to participate in ACIA. This change is reflected in the updated Attachment C.

CMS Response 7/8/22: Based on the final Attachment C, we understand that there are now 406 enrolled providers, and 392 requested to participate in ACIA. Please confirm.

State Round 4 Response: The state confirms this understanding.

b. Of the 394 hospitals:

i. Before a reduction is applied to maintain payments at 90% of ACR, there are 240 with an inpatient ACIA rate greater than 0% and 237 with an outpatient ACIA rate greater than 0%.

State Round 3 Response: After accounting for the one provider withdrawal, there are now 241 hospitals with an inpatient ACIA rate greater than 0% and 237 hospitals with an outpatient ACIA rate greater than 0%.

CMS Response 7/8/22: Based on the final Attachment C, we understand that there are now 239 with an inpatient ACIA rate greater than 0% and 239 with an outpatient ACIA rate greater than 0%. Please confirm.

State Round 4 Response: The state confirms this understanding.

ii. After a reduction is applied to maintain payments at 90% of ACR, there are 173 with an inpatient ACIA rate greater than 0% and 230 with an outpatient ACIA rate greater than 0%.

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State Round 3 Response: The state affirms these numbers are still accurate.

CMS Response 7/8/22: Based on the final Attachment C, we understand that there are now 172 with an inpatient ACIA rate greater than 0% and 231 with an outpatient ACIA rate greater than 0%. Please confirm.

State Round 4 Response: The state confirms this understanding.

- c. By filtering columns Y, AC, and AD, there are 100 hospitals that requested participation in ACIA but have a 0% rate increase for both ACIA inpatient and outpatient. Can the state please confirm this estimation and confirm our understanding that these 100 hospitals have 0% for ACIA because they have a UHRIP rate greater than ACR? We understand that all qualifying hospitals provided ACR data to the state for SFY 2023, so that would not be a reason for any hospital to have a 0% ACIA rate.

State Round 3 Response: On the updated Attachment C, the state affirms that 98 hospitals requesting participation in ACIA will receive 0% for both the inpatient and outpatient ACIA component prior to the reduction to maintain payments at 90% of ACR. After the reduction, 131 hospitals that requested participation in ACIA will receive 0% for both inpatient and outpatient. Several of these providers show a negative ACR UPL gap, which will result in a 0% award. The ACR UPL gap is a payment to charge ratio multiplied by the Medicaid charges, less Medicaid payments. A provider would also have a 0% ACIA rate if its ACR UPL gap goes negative after considering UHRIP payments, if the provider has \$0 projected encounters, or if, after maintaining payments at 90% of ACR, the ACIA percentage goes to zero.

2. In looking at the "Avg Increase by SDA and Class tab",

- a. We note that there are no providers in the MRSA Northeast Non-State-Owned IMD, Harris State-Owned IMD, and Dallas State-Owned IMD classes participating in UHRIP nor ACIA for SFY 2023. Is that correct? We note that there were no providers in the MRSA Central State-Owned IMD class participating in UHRIP nor ACIA in SFY 2022, but this appears to have changed for SFY 2023 – can the state please confirm?

State Round 3 Response: The tab shows Dallas State-Owned IMD class participation in UHRIP, but not ACIA. The state affirms that MRSA Northeast Non-State-Owned IMD and Harris State-Owned IMD are not participating in UHRIP or ACIA. The state also affirms that there is one provider in MRSA Central State-Owned IMD classification participating for SFY2023 that was not enrolled in SFY2022.

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- b. Do the following classes have average UHRIP and CHIRP rate increases of 0% because they do not have a positive Medicare gap, they are not participating in ACIA, and also had \$0 in inpatient/outpatient encounters: State-Owned IMD MRSA Central, State-Owned IMD MRSA Northeast, State-Owned Non-IMD Bexar?

State Round 3 Response: There is only one provider in each of these classes (3 total), and for each provider, there were \$0 in inpatient and outpatient Medicaid encounters.

3. In the "Revised Question 19b" tab,

- a. Can the state please explain what is contributing to the significant rate increases for the Urban class:

- i. Maximum inpatient ACIA rate increase = 3756% 5046%
- ii. Maximum inpatient total CHIRP rate increase = 3830% 5130%
- iii. Maximum outpatient ACIA rate increase = 3028% 3077%
- iv. Maximum outpatient total CHIRP rate increase = 3058% 3107%

State Round 3 Response: For each of these calculated values, the numerator is the ACR gap less estimated UHRIP payment, and the denominator is the trended encounters. The calculated numerator was much higher than the denominator of trended encounters, resulting in the significant rate increases. Please also note that the value for iii. Maximum outpatient ACIA rate increase = 3031%.

CMS Response 7/8/22: Thank you for providing additional information about the methodology. We note that the updated data in Attachment C demonstrates even higher rate increases. Please provide additional detail as to what factors are driving the significant rate increases, for example, is the increase attributable to specific hospitals in this class.

State Round 4 Response: The finalized actuarial trended encounters used in the latest calculation are smaller than the preliminary encounters used in prior versions. The encounters are the denominator in the calculation for the rate increases, and a smaller denominator resulted in higher rate increases.

- b. Can the state please explain what is contributing to the significant rate increases for the Rural class:

- i. Maximum outpatient ACIA rate increase = 724% 432%
- ii. Maximum outpatient total CHIRP rate increase = 737% 450%

State Round 3 Response: These rate increases are attributable to one provider who, since the time of this submission, has requested a correction to their self-reported ACR data. The correction has resulted in a smaller rate increase for the ACIA component, and thus the overall CHIRP rate. Please see the updated Attachment C for current values.

CMS Response 7/8/22: Thank you for the update. We noticed that the maximum outpatient ACIA rate increase changed to 432% and the maximum outpatient total CHIRP rate increase changed to 450%. This still

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represents a relatively high increase; could the state please explain what is contributing to the significant rate increase?

State Round 4 Response: Rural hospitals typically provide a lower volume of services, so in calculating the percentage increase for ACIA, the difference in the ACR gap - UHRIP is divided by fewer trended encounters when compared to other provider types. Additionally, rural hospitals routinely maintain chargemasters that are much closer to their typical payment agreements as they consider the impact to non-Medicaid clients who may be required to pay a percentage of charges. When calculating a payment to charge ratio with commercial data, and then applying that resultant ratio against their Medicaid charges, the resulting ACR gap may appear high, as well as the resulting percent rate increase. With comparatively fewer total encounters the percentage that is calculated in the example cited by CMS is 432% and 450%.

c. Can the state please explain what is contributing to the significant rate increase for the State-Owned IMD class:

i. Maximum inpatient UHRIP and maximum inpatient total CHRIP rate increase = 353%

State Round 3 Response: To calculate the UHRIP component, the summarized Medicare UPL gap is divided by the trended encounters. This particular class and SDA had a significantly large Medicare UPL gap, and small trended encounters, resulting in the large rate increase.

4. In the "Summary" tab, the state estimates that total PGY 6 encounters will equal \$5,500,787,699. For the SFY 2022 review, the estimate for PGY 5 encounters was \$4,587,183,211. What factors contributed to the increased estimate for PGY 6?

State Round 3 Response: Caseload growth is the main driver of the growth in the program. Please note these encounters are still preliminary, so this number will likely change.

b. Previously, CMS recommended that the state consider implementing monitoring and/or auditing efforts to investigate outliers in CHIRP data that is self-reported to the state by the providers. Can the state please provide an update on the implementation of these efforts?

State Response: Submitted Average Commercial data will be analyzed by comparison across total submissions and compared across class/SDA with outliers identified. Outliers that are identified will be further compared to Medicaid billing data to confirm consistency with average commercial payments self-reported by providers. The state will communicate with any providers who are identified as having provided outlier data to confirm self-reported data is correct. Following confirmation of submitted data the state will continue to analyze submitted data on a year over year basis.

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CMS Response (5/11/22): Were any outliers identified based on data submitted by hospitals for the SFY 2022 rating period?

State Round 2 Response: The state has not concluded calculation and data aggregation at this time but will provide an update at a later date related to outliers. If outliers are identified, HHSC plans to work with those providers to confirm the veracity of the data prior to finalizing the rate increases and estimated payments in mid-June.

CMS Response 7/8/22: Thank you for providing CMS a list of outlier hospitals for which the state did outreach to confirm the validity of the data that is self-reported to the state. Can the state please describe how the 21 outlier hospitals were identified to be considered an "outlier"?

State Round 4 Response:

There were a few ways the outliers were identified:

- (1) Statistical outliers: Inpatient and outpatient ACR payment to charge ratios were compared separately. HHSC calculated the inner quartile range (IQR) which is quartile 3 minus quartile 1. Then any provider that had a value less than quartile 1 – 1.5*IQR or more than quartile 3 + 1.5*IQR was identified as an outlier.
- (2) Duplicate data for SFY2022 and SFY2023: If a provider had the same average commercial data reported for both years of CHIRP, they were contacted.
- (3) Duplicate data for two providers: If two providers had the exact same data, they were contacted.
- (4) SFY2022 to SFY2023 analysis: Hendrick Medical Center was also identified as an outlier. They had a significant drop in their outpatient ACR payment to charge ratio from SFY22 to SFY23. In addition, they notified the state of an error in their application where they reported information, which was the cause for the significant drop in PCR.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

6. Preprint Question 20:

- a. Are there any provider classes new to this preprint submission?

State Response: All provider classes are identical to what was approved for CHIRP SFY2022.

7. Preprint Question 21 (Attachment C):

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

State Response: The due date for application submission was March 29, 2022.

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CMS Response (5/11/22): Is the state able to report the number of enrollment applications received and how this compares to the applications received for SFY 2022?

State Round 2 Response: The number of enrolled applicants for CHIRP SFY2023 is 408, compared to 418 applicants for SFY2022.

CMS Response (6/3/22): Thank you for this information. Is the number of enrolled hospitals (i.e., 408) subject to change, or is this the final count?

State Round 3 Response: Since the time of submission, there has been one provider withdrawal from the program, resulting in 407 enrolled providers. The newly submitted Attachment C is current as of June 3, 2022.

CMS Response 7/8/22: We understand with the June 30, 2022 submission, there are now 406 enrolled providers. In this number of enrolled providers subject to further change?

State Round 4 Response: The state affirms this is the final enrollment total and will not change again.

- b. Could the state confirm if the magnitude of the UHRIP and ACIA increases provided in the “Q21 Hospital Rates” tab of Attachment C are the final rate increases that will be paid during the SFY 2023 rating period? If they are not, when will they be available?

As was the case for the SFY 2022 preprint review, CMS will need the state to provide the actual uniform percentage increases for each hospital class and SDA for UHRIP and for each hospital for ACIA being requested under the preprint. The state will also need to provide an updated reimbursement analysis based on these new UHRIP and ACIA uniform percentage increases. This reimbursement analysis should show the impacts of the uniform percentage increases for both UHRIP and ACIA and across all hospitals.

State Response: The rates in the submitted pre-print and attachments are representative of SFY2022 rating period. HHSC will calculate final rate increases based on the FY 2023 applications, consistent with the methodology in the pre-print; final rate increase percentages and amounts are anticipated to be available in late May or early June, as the state finalizes details about caseload and utilization projections for the FY 2023 rating period.

CMS Response (5/11/22): Is it still the case that the revised rate increases and estimated payments will be ready to share with CMS in late May or early June? CMS will need this information as part of our review of this SFY 2023 proposal.

State Round 2 Response: HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. HHSC will provide the final documents to CMS as soon as they are available. However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors

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and caseload assumptions to help expedite CMS' review. Please see updated preprint and attachments.

CMS Response (6/3/22):

1. In reviewing the "Revised Q21 Hospital Rates" tab, is the following accurate?

a. There appears to be 23 hospitals reported as 0% inpatient UHRIP increase but are reported as having an inpatient ACIA rate increase.

State Round 3 Response: On the updated Attachment C, 24 providers have a 0% inpatient UHRIP increase but have an inpatient ACIA rate increase.

b. There appears to be 3 hospitals reported as 0% outpatient UHRIP increase but are reported as having an outpatient ACIA rate increase.

State Round 3 Response: Yes, that's correct.

c. It appears that 158 facilities would receive an inpatient CHIRP increase of over 100% of negotiated rates; 28 of these facilities would receive an inpatient CHIRP increase of over 200% of negotiated rates.

State Round 3 Response: On the updated Attachment C, the state affirms that 155 facilities would receive an inpatient CHIRP increase over 100%; of those, 28 would receive an inpatient CHIRP increase over 200%.

d. It appears that 70 facilities would receive an outpatient CHIRP increase of over 100% of negotiated rates; 15 of these facilities would receive an outpatient CHIRP increase of over 200% of negotiated rates.

State Round 3 Response: On the updated Attachment C, the state affirms that 69 facilities would receive an outpatient CHIRP increase over 100%; of those, 14 would receive an outpatient CHIRP increase over 200%.

2. In reviewing the "CHIRP Payment Calc" tab and the "Revised Q21 Hospital Rates" tab, we identified the following hospitals with significant CHIRP increases (either CHIRP inpatient and/or outpatient increase is above 248%). Can the state please discuss what is driving these significant rate increases for these hospitals?

State Round 3 Response: For each of these calculated values, the numerator is the ACR gap less estimated UHRIP payment, and the denominator is the trended encounters. The calculated numerator was significantly higher than the denominator of trended encounters, resulting in the significant rate increases.

CMS Response 7/8/22: CMS has reviewed the state's outlier analysis and did not see the twelve hospitals listed below within the analysis. Please provide further context regarding the magnitude of the rate increases for each hospital. Note that we have updated the CHIRP increases per hospital based on the most recent data included in the "CHIRP Payment Calc" tab of Attachment C.

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State Round 4 Response: The above response is still accurate. The outlier analysis was conducted on the self-reported ACR payments and charges submitted with the application for enrollment, not the awarded rate increases. There are several factors that could impact the ultimate rate increase that is received by a provider because the underlying data to calculate the Medicare and ACR gaps are derived from different sources than the encounters that are presumed to actually be paid in the coming program period. The encounter payments that are estimated for the program period may vary significantly from the historical data that is used to calculate the gaps due to trend factors, in- or out-of-network status, ownership changes/mergers, etc. The encounter payments estimated are inclusive of only in-network expenditures, but a specialty hospital (like one of the heart hospitals listed below), might provide services to an out-of-network Medicaid client that needs a particular procedure, or a hospital in an urban area may provide services to someone who is transferred in from an area that does not have the ability to handle the client's level of acuity. The payments and charges associated with that out-of-network client are included in the UPL test when the Medicare and ACR gaps are calculated, but there are not presumed encounter payments associated with such an out-of-network client in the program model. However, the analysis of the underlying data used to determine the percent rate increases does not indicate that these facilities have anything occurring in their reported data that is remarkable or concerning to the state.

a. Urban Dallas Class/SDA: Baylor Heart & Vascular Center LLP has an inpatient CHIRP increase of 700% and outpatient CHIRP increase of 3058%.

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: Baylor Heart & Vascular Center LLP has an inpatient CHIRP increase of 705% and outpatient CHIRP increase of 3107%.

State Round 4 Response: See answer to question 2 above.

b. Urban Dallas Class/SDA: Texas Heart Hospital of the Southwest LLP has an inpatient CHIRP increase of 1379% and outpatient CHIRP increase of 1313%.

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: Texas Heart Hospital of the Southwest LLP has an inpatient CHIRP increase of 1393% and outpatient CHIRP increase of 1321%.

State Round 4 Response: See answer to question 2 above.

c. Urban Dallas Class/SDA: Baylor Regional Medical Center at Plano has an inpatient CHIRP increase of 532% and outpatient CHIRP increase of 1389%

State Round 3 Response: See answer to question 2 above.

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CMS Response 7/8/22: Baylor Regional Medical Center at Plano has an inpatient CHIRP increase of 542% and outpatient CHIRP increase of 394%.

State Round 4 Response: See answer to question 2 above.

d. Urban Dallas Class/SDA: Texas Health Presbyterian Hospital Kaufman has an inpatient CHIRP increase of 315%

i. Urban Dallas

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: Texas Health Presbyterian Hospital Kaufman has an inpatient CHIRP increase of 324%.

State Round 4 Response: See answer to question 2 above.

e. Urban Tarrant Class/SDA: Baylor Regional Medical Center at Grapevine has an inpatient CHIRP increase of 3830% and outpatient CHIRP increase of 540%.

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: Baylor Regional Medical Center at Grapevine has an inpatient CHIRP increase of 5130% and outpatient CHIRP increase of 600%.

State Round 4 Response: See answer to question 2 above.

f. Urban Tarrant Class/SDA: Medical City North Hills has an inpatient CHIRP increase of 296%.

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: Medical City North Hills has an inpatient CHIRP increase of 312%.

State Round 4 Response: See answer to question 2 above.

g. Urban Tarrant Class/SDA: Medical City Fort Worth has an inpatient CHIRP increase of 248%

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: Medical City Fort Worth has an inpatient CHIRP increase of 261%.

State Round 4 Response: See answer to question 2 above.

h. Urban Travis Class/SDA: CHRISTUS Santa Rosa Hospital-San Marcos has an inpatient CHIRP increase of 1043%.

State Round 3 Response: See answer to question 2 above.

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CMS Response 7/8/22: CHRISTUS Santa Rosa Hospital-San Marcos has an inpatient CHIRP increase of 1084%.

State Round 4 Response: See answer to question 2 above.

i. Urban Jefferson Class/SDA: Baptist Hospitals of Southeast Texas has an inpatient CHIRP increase of 314%

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: Baptist Hospitals of Southeast Texas has an inpatient CHIRP increase of 367%.

State Round 4 Response: See answer to question 2 above.

j. Urban Lubbock Class/SDA: Lubbock Heart Hospital LLC has an outpatient CHIRP increase of 318%

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: Lubbock Heart Hospital LLC has an outpatient CHIRP increase of 327%.

State Round 4 Response: See answer to question 2 above.

k. Urban El Paso Class/SDA: The Hospitals of Providence Sierra Campus has an inpatient CHIRP increase of 292%

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: The Hospitals of Providence Sierra Campus has an inpatient CHIRP increase of 301%.

State Round 4 Response: See answer to question 2 above.

l. Rural MRSA West Class/SDA: Hendrick Medical Center Brownwood has an outpatient CHIRP increase of 365%.

State Round 3 Response: See answer to question 2 above.

CMS Response 7/8/22: Hendrick Medical Center Brownwood has an outpatient CHIRP increase of 450%.

State Round 4 Response: See answer to question 2 above.

3. Has the state done a comparison of rate increases from this year and last, and identified any outliers? For instance, we note that for Baylor Regional Medical Center at Grapevine that is referenced above, for SFY 2023, their preliminary inpatient CHIRP increase is 3830% and outpatient CHIRP increase is 540%. While our records show that for SFY 2022, this facility had an inpatient CHIRP increase of

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77% and an outpatient CHIRP increase of 66%. Can the state please discuss if this is an outlier and what may be driving this variation.

State Round 3 Response: An analysis of outliers has not been completed at this time. However, for the provided example, Baylor Regional Medical Center at Grapevine was a newly-built facility and, consequently, did not have data available for the time period used for trended encounters. Without the data, the provider had a trended encounter value of \$0 and an understated ACR UPL gap. With more complete data available for SFY2023, the provider now has a rate increase more representative of Medicaid encounter caseload.

- c. For hospitals participating in only UHRIP and not ACIA, how many hospitals does that state anticipate for SFY 2023 would receive payments above the average commercial rate?

State Response: Although the enrollment period has closed, calculating the UHRIP and ACIA components is still in progress.

CMS Response (5/11/22): Please share this information when it is available.

State Round 2 Response: HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. HHSC will provide the final documents to CMS as soon as they are available. However, per our call on May 13, 2022, HHSC understands that CMS would appreciate receiving the preliminary rate increases and estimated payments based upon the draft trend factors and caseload assumptions to help expedite CMS' review. Please see updated preprint and attachments

CMS Response (6/3/22):

1. In looking at the "IP UHRIP-only" tab, there are 235 hospitals listed as only participating in UHRIP inpatient.
 - a. In looking at the "Total Inpatient Payment Level" column, it appears that 93 of the hospitals have a total inpatient payment level that is below the ACR, and 111 hospitals have a total inpatient level that is above the ACR. Is this a correct estimation?

State Round 3 Response: On the updated Attachment C, there are now 234 hospitals participating in UHRIP only. Of those, 95 have a total inpatient payment level below the ACR UPL after estimated UHRIP payments are included, and 109 have a total inpatient level above the ACR UPL after estimated UHRIP payments are included.

CMS Response 7/8/22: Based on this analysis, CMS understands that there are 111 hospitals that have total inpatient payment above their ACR but will not need to comply with the ACIA requirements. Does the state have concerns about this?

State Round 4 Response: The state has no concerns as the basis for the UHRIP payments is the Medicare UPL and all the hospitals referenced in the

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question will be required to comply with the conditions of participation related to UHRIP.

- b. Can the state please clarify if the “N/A” entries in the “Total Payment Level” column will be corrected with the final submission?

State Round 3 Response: This is not an error, but rather a text output of the Excel "IFERROR" formula. The ACR UPL is zero for these providers, so the division formula would result in a "#N/A" without the "IFERROR" formula. The "N/A" indicates that a payment level cannot be calculated for that provider.

2. In looking at the “OP UHRIP-only” tab, there are 175 hospitals listed as only participating in UHRIP outpatient.

- a. In looking at the “Total Outpatient Payment Level” column, it appears that 10 of the hospitals have a total outpatient payment level that is below the ACR, and 80 hospitals have a total outpatient level that is above the ACR. Is this a correct estimation?

State Round 3 Response: On the updated Attachment C, there are now 177 hospitals participating in UHRIP only. Of those, 63 have a total inpatient payment level below the ACR UPL, and 78 have a total inpatient level above the ACR UPL.

CMS Response 7/8/22: Based on this analysis, CMS understands that there are 76 hospitals that have total outpatient payment above their ACR but will not need to comply with the ACIA requirements. Does the state have concerns about this?

State Round 4 Response: The state has no concerns as the basis for the UHRIP payments is the Medicare UPL and all the hospitals referenced in the question will be required to comply with the conditions of participation related to UHRIP.

- b. Can the state please clarify if the “N/A” entries in the “Total Payment Level” column will be corrected with the final submission?

State Round 3 Response: This is not an error, but rather a text output for the Excel "IFERROR" formula. The ACR UPL is zero for these providers, so the division formula would result in a "#N/A" without the "IFERROR" formula. The "N/A" indicates that a payment level cannot be calculated for that provider.

- d. Can the state please confirm that for SFY 2023 rating period, there are no hospital classes/SDAs where the total payments will exceed the ACR?

State Response: The state confirms that no total payments for hospital classes/SDAs will exceed the ACR in SFY2023.

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- e. It appears as though there may be errors in how the pass-through-payments are addressed in the “IP CHIRP Payment Levels – All” tab as the values between column N and S are inconsistent in some cases. Can the state please verify?

State Response: The state sees no discrepancy in formulaic or mathematical structure for the mentioned columns. If CMS believes a discrepancy exists, HHSC would appreciate additional clarification from CMS about the perceived discrepancy, including what the discrepancy is.

CMS Response (5/11/22): We note that one example of a discrepancy is row 19 where column N is 23 percent and column S is 0 percent.

State Round 2 Response: The state has produced a new IP CHIRP Payment levels tab for SFY2023 with the Attachment C update based on preliminary data. The formula has been updated as seen on row 19 (now 25% in column N, and 25% in column S).

8. In SFY 2022, the state had a minimum fee schedule requirement for rural hospital inpatient and outpatient services tied to the state plan rate. Can the state confirm if this minimum fee schedule requirement will still be in effect for SFY 2023?

State Response: The state confirms that the minimum fee schedule requirement is still in effect for SFY 2023.

9. The SFY 2022 approval letter indicated, “CMS understands that upon approval of this state directed payment, the state will solicit average commercial rate (ACR) data, as a condition of participation, from the hospitals participating in CHIRP that have not provided this data to the state. As discussed with Texas, should a hospital fail to provide their respective ACR data as a condition of participation in CHIRP, that hospital would no longer be eligible for CHIRP payments and any modifications to the capitation rates as a result of this change would need to go back to the effective date of CHIRP, which is September 1, 2021”. Please provide an update on the collection of this ACR data. Have all hospitals participating in CHIRP for SFY 2022 provided their ACR data to the state?

State Response: As of April 13, 2022, all but six of the providers have responded with their SFY2022 ACR data. The state is actively communicating with the remaining providers in an effort to secure ACR data as a condition of those providers’ participation in CHIRP.

CMS Response (5/11/22): Please provide an update on the six remaining providers that had not responded with SFY 2022 ACR data. Additionally, has the state been able to collect ACR data from all the providers participating for SFY 2023?

State Round 2 Response: As of May 11, 2022, all but six of the providers have responded with their SFY2022 ACR data. All providers for FY23 responded with ACR data as a part of the FY23 application process.

CMS Response (6/3/22): Thank you for this information. Can the state please clarify/confirm that the revised Attachment C with the preliminary modelling accounts for the ACR data provided for SFY 2023? Can the state identify who are the remaining six hospitals who have yet

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to provide SFY 2022 ACR data? What is the state's timeline for getting this data and have these six hospitals provided ACR data for SFY 2023?

State Round 3 Response:

Attachment C for the SFY2023 preprint includes calculated ACR data from all providers that have enrolled. Please see the table below for the outstanding providers who have not submitted ACR data for SFY2022. The state maintains continued communications with the below providers to obtain requested ACR data. Of the following providers, only Memorial Hospital is enrolled in SFY2023. The State is working to obtain this information as soon as possible, with the goal to have all collected by the end of June.

CMS Response 7/8/22: Can the state provide CMS an update as to the collection of ACR data or SFY 2022 from the 6 hospitals below? What will be the cut-off deadline for the hospitals to provide this data for SFY 2022?

State Round 4 Response: All providers except Memorial Hospital, Shamrock General Hospital, and Carrollton Springs have now complied. HHSC has solicited assistance from hospital associations in the state to try to obtain information from the remaining hospitals. HHSC plans to allow the hospitals to have until July 31, 2022 to provide the requested information. In the event that they have not provided the information at that time, HHSC plans to seek technical assistance from CMS regarding the removal of the providers from the program and any documentation that will be required by CMS.

NPI	PROVIDER NAME
1821025990	MEMORIAL HOSPITAL
1326349986	SCOTT AND WHITE HOSPITAL - LLANO-BAYLOR SCOTT AND WHITE MEDICAL CENTER - LLANO
1538150370	SHAMROCK GENERAL HOSPITAL
1134401466	CARROLLTON SPRINGS LLC
1821612284	Kindred BH Acquisition 1, LLC d/b/a WellBridge Hospital Greater Dallas
1285258640	Kindred BH Acquisition 2, LLC d/b/a WellBridge Healthcare Fort Worth

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SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

10. Will the state include the UHRIP and ACIA portions of the payment in the capitation rates in a manner consistent with prior years? If not, please describe the differences in the methodology this year.

State Response: Yes.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

General Comment: The financing of the CHIRP state directed payment appear to be financed by local units of government providing intergovernmental transfers (IGTs), funds for which are largely derived from the taxing authority of these units of government through the Local Provider Participation Fund, or LPPF. 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.

11. The CHIRP spreadsheet appears to indicate that Coryell County Memorial, Decatur, Fannin County, and Uvalde County Hospital Authorities all do not have taxing authority and do not receive an appropriation. Please indicate where the funds for the IGTs for these entities come from for purposes of this state directed payment.

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](#). 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.

CMS Response (5/11/22): We appreciate the state's responses to our Round 1 questions. The state's responses to questions # 11 & 13 do not seem to address the questions raised by CMS. Can the state provide any specifics regarding where the funding for the specific entities in the state's IGT entity list will be coming from?

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

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

State Round 3 Response: We appreciate the feedback on our ongoing monitoring efforts.

CMS Response 7/8/22: 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 upon request.

12. In "Attachment F – IGT Entities" - several entities are classified as "other" under operational nature. Please define the operational nature for each of these entities as most are not classified as typical IGT-eligible entities (i.e. state, county, city).

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

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13. For any entities that may or may not have taxing authorities and do not receive any state appropriated funds, please describe where the funding for those IGTs will come from. 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 appropriations, commercial patient revenue where the entity is a service provider, or other available public funds.

Please see additional information regarding non-taxing public entities above for examples.

14. 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.

CMS Response (5/11/22): Regarding the state's response to question #14, is there any expectation from the IGT entities regarding their voluntary contribution of the IGT? Do the IGT entities expect any return of any payment from the local providers that are the recipients of the payments? If so, what information was provided to these entities about rules regarding the reassignment of payments under 42 CFR 447.10?

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

CMS Response (6/3/22): Thank you for this information. We urge Texas to gather such information from local entities that contribute to the non-federal share of Medicaid payments to have a full accounting of the entities that contribute to the financing. We advise the state to conduct oversight on the sources of non-federal share that are used to finance Medicaid payments and to thoroughly understand the underlying sources of financing that localities rely upon to source IGTs. Based on information provided by the state, there appear to be entities that do not have access to tax revenue or appropriations and that may rely on bonds or other debt instruments as a source of non-federal share revenue. We would urge the state to

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examine the sources of financing that those entities use to source IGTs as a starting point in your oversight efforts and to further work with localities to identify where bonds or debt instruments are used to finance the non-federal share of Medicaid payments. We will continue to follow up on the work of the state oversight body, and reaffirm the state's obligation to ensure that funding for Medicaid payments are derived from allowable sources.

State Round 3 Response: We appreciate the feedback on our ongoing monitoring efforts.

15. Please confirm that the list of IGT Entities are consistent from the original submission (control name TX_Fee_IPH.OPH.BHI_New_20210901-20220831) 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 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.

CMS Response (5/11/22): We appreciate the state's response to question #15. In the event that the oversight body is not set up before the IGTs are sent to the Medicaid agency, and payments are made to the providers, are there any interim steps that will be taken to ensure that all funds transferred meet the federal requirements for IGTs?

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

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

State Round 3 Response: We appreciate the feedback on our ongoing monitoring efforts.

16. 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

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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. .

CMS Response (5/11/22): Regarding question #16 & 19, 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: We appreciate the feedback on our ongoing monitoring efforts.

17. In item #12 of the CHIRP application, the language says: "By checking this box, I certify, as the entity that owns the hospital, that no part of any payment made under CHIRP will be used to pay a contingent fee and that the agreement with the hospital does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the hospitals' receipt of CHIRP funds." Please elaborate on what is intended by the inclusion of this statement.

State Response: The state has a similar requirement in its Medicaid provider enrollment agreement. Because the state is requiring information about commercial payments and charges for which the state could not obtain the data independently, we included this statement to remind providers of their responsibility under the terms of the Medicaid enrollment agreement related to third party billing entities, as we believe that this is applicable also to an application preparer or the provider in this context.

18. The CHIRP application seems to suggest that the city/county/hospital district can choose which hospitals/types of hospitals can benefit from the IGT/supplemental payments. Item #14 in the list says: "As a sponsoring governmental entity, which class or classes of hospitals do you wish to support through IGTs of public funds? This information will be used to calculate suggested IGT responsibilities." The form proceeds to list out various types of hospitals classes. Section 1902(a)(2)

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of the Act says that the state plan must provide “ for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.” If a government entity limits which providers may benefit from an IGT, how does the state assure that any hospitals that qualify under the CHIRP program will have their underlying payments fully funded as proposed under the CHIRP program?

State Response: Texas distributes a suggested list of IGT amounts to governmental entities based on the Medicaid utilization and services already provided in each governmental entity’s jurisdiction. In many of our Service Delivery Areas, several governmental entities may wish to transfer eligible public funds via IGT, and this advance notice of each governmental entity’s intent to fund helps HHSC to apportion the suggestions and confirm that providers receive funding in accordance with their entitlement to such funds. However, the suggestions are non-binding, and local governments may transfer whatever amount they wish at the time that IGT is collected. When IGT is collected, it is pooled for all classes in the service delivery area. Governmental entities do not limit which providers may benefit from an IGT.

19. Similar to the original submission (control name TX_Fee_IPH.OPH.BHI_New_20210901-20220831), CMS notes 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,

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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 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.

20. 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

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or by showing Texas must show that it is acting to end any such arrangements that are in place, including by issuing guidance to its providers that such practices constitute impermissible hold harmless arrangements. Can the state please confirm that its position on this issue has not changed?

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

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

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

CMS Response 7/8/22: CMS does not have additional questions on the LPPFs at this time. Please note that we continue to harbor the same hold harmless concerns as we did for the SFY 2022 pre-prints for CHIRP, TIPPS, and RAPPs that are financed by LPPFs.

State Round 4 Response: Noted.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

23. **New CMS Question 7/8/22:** We understand that the state is participating in the CHART model. We understand from our discussions that participation in this model may impact CHIRP and RAPPS, but does not have any implications for SFY 2023. Can the state please confirm that only future rating periods for CHIRP and RAPPS may be implicated by the state’s participation in the CHART model.

State Round 4 Response: That is correct. CHART will not affect CHIRP or RAPPS for SFY 2023.

Round 4 Question Set

July 8, 2022

24. New CMS Question 7/8/22: We also understand that the state operates a hospital quality-based payment program, that is separate from this CHIRP state directed payment and involves disincentives related to performance on Potentially Preventable Readmissions and Complications measures. We understand from the state that this payment arrangement is not a state directed payment, in that it is not a requirement in the MCO contracts and that all adjustments in term of penalties are assumed in base data for capitation rate development. Participation in the hospital quality-based payment program does count towards the APM requirements in the MCO contracts, but the managed care plans are not required to participate. Can the state please clarify/confirm this understanding.

State Round 4 Response: That is correct. The state affirms this understanding.