TX_Fee_Oth1_Renewal_20220901-20230831 (RAPPS)
Round 4 Question Set
July 7, 2022

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: 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: 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.

    CMS Response (5/11/22): When does the state anticipate being able to provide the final component and non-benefit cost provision amounts to CMS?

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

    Based on the preliminary modeling, the total dollars are now:

        i. Component 1 - $22,325,039
        ii. Component 2 - $7,442,837
        iii. Administration, profit margin, or premium tax - $1,825,755

    CMS Response (6/3/22):
    1. For the SFY 2022 rating period, the state provided a total dollar estimate of $11,264,178 for the RAPPS 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 RAPPS for SFY 2022?
    2. For the SFY 2023 rating period, the state provides a total dollar estimate of $31,593,631. Can the state please discuss the reasoning behind the increase in the in the total dollar estimate from SFY 2022 to SFY 2023? We understand from our call

on May 25, 2022 that the total dollar increase is being driven by caseload growth assumptions related to the public health emergency. Please further describe this reasoning.

3. Does the state anticipate this total dollar amount changing with the final submission?

State Round 3 Response:

1- As of May 31, 2022, total payments for the SFY2022 RAPPS directed payment program are approximately $6.36 million for the first six months of the program. Based on the total spent for the first six months, the estimated annualized total for SFY2022 will be $12.73 million. The estimated annualized total expenditure is subject to change.

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

State Round 4 Response: Annualized expenditures for SFY22 are estimated to be $12,911,862 but the rating period will not conclude until August 31, 2022, so that total is subject to change.

2- For the SFY2023 rating period, please note that the total dollar estimate is now $31,515,156. The pool size decreased from initial estimates because 5 RHCs opted out of RAPPS. There are numerous factors driving the change in pool size that work together in a complex manner, but caseload growth is the main driver of the growth in the program. The growth factors were applied to the Medicare gaps which were used to determine the pool size. A second major factor contributing to the increase is the average Medicare rate increased by 14% between SFY2022 and SFY2023 for participating providers. The magnitude of the change to the Medicare gap from the increase in Medicare rate varies based on the number of units for that RHC. There were also significant Medicaid unit/payment changes between SFY2022 and SFY2023, in some cases based on changes in network status, since all calculations are using in-network data only.

3- Yes, the total dollar amount will change with the final submission.

Based on the preliminary modeling, the total dollar amounts are now:

i. Component 1 - $22,269,244
ii. Component 2 - $7,424,708
iii. Administration, profit margin, or premium tax - $1,821,203

CMS Response 7/7/22: Based on the final total dollar amount estimate, can the state please update the estimates above for Component 1, Component 2, and Administration, profit margin, or premium tax?

State Round 4 Response:

Based on the final estimates, the total dollar amounts are now:

i. Component 1 - $22,028,275
ii. Component 2 - $7,343,363
iii. Administration, profit margin, or premium tax - $1,802,042

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: 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: No, the state plans to use the same time frame as a basis for the SFY2023 submission with different trends applied.

        CMS Response (5/11/22): Can the state please explain why the state is not using more current utilization for the SFY 2023 submission?

        State Response Round 2: The state seeks to use a non-COVID time period in order to more closely reflect what utilization will be in SFY 2023. The state requests to use Pre-COVID-19 data (March 2019 – February 2020) because of the impact that COVID-19 and maintenance of eligibility (caseload) has had on Medicaid costs and utilization. More recent time periods have been distorted by these impacts, and do not align with anticipated costs and utilization in fiscal year 2023. In our opinion, using a pre-pandemic time period as a starting assumption is reasonable and appropriate.

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: The annual reconciliation should say for "SFY2023 utilization". Attachment B has been revised.

CMS Response 7/7/22:

1. Within the paragraph describing Component 1, the state says, "Final numbers will be provided when available in June". Can the state please clarify if final numbers have been provided and if so, please remove this language.
2. Within the paragraph describing Component 2, the state says, "For Component 2, the preliminary uniform percent increase is approximately 10.77% for all rural health clinics." Will the state be submitting a revised preprint to reflect a final percent increase for Component 2?

State Round 4 Response: These are the final numbers. The language in Attachment B has been updated accordingly, and the attachment has been renamed with 07.07.2022 at the end. A revised preprint is also included with this submission.

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

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

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

iii. Please provide an explanation of what amount will be targeted for the reconciliation.
State Response: The reconciliation for the RAPPS program will be based on actual utilization, and an independent reconciliation will be completed for Component 1.
CMS Response 6/3/22: During the SFY 2022 RAPPS preprint review, we understood that the reconciliation performed at the end of the program year will be performed to reconcile to the actual value of Component 1 based upon the actual value of the overall program as paid through the program year. If the actual program size fluctuates as a result of caseload, the size of Component 1 would fluctuate proportionately as Component 1 is designed to be equal to a percentage of the overall program value. Does the state plan to use this reconciliation methodology for RAPPS Component 1 for SFY 2023?

State Round 3 Response: Yes, that is correct. The reconciliation will be performed within 120 days of the end of the program year to reconcile the amount paid throughout the program year based on historical data to the actual utilization and value of the overall program within that year.

iv. The state indicated the following during the SFY 2022 review of TIPPS. Has any of this changed for SFY 2023 TIPPS payments?
1. The state's intent is that there will be no changes to the payments that the MCO receives from the state; payment changes would occur only for the providers.
2. The state will inform the MCOs via a payment scorecard that will show any provider level payment adjustments that are required.

State Response: With respect to the first above statement, once HHSC completes the reconciliation of 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: Enrollment opened on March 2, 2022 and closed on March 29, 2022. Processing of enrollment is estimated to be completed in late April 2022.

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

State Round 2 Response: As of May 14, 2022, 163 of the 198 providers that requested to participate in RAPPS qualified.

CMS Response (6/3/22): Our records indicate that for SFY 2022, there were 17 Freestanding clinics and 164 Hospital-based clinics participating in RAPPS, so a total of 181 providers. Is that correct? For SFY 2023, there will be approximately 18 fewer providers compared to SFY 2022?

State Round 3 Response: That was the correct number of SFY2022 clinics. For SFY2023, 5 RHCs opted out of the program following enrollment – 4 hospital-based RHCs, and 1 freestanding RHC. Therefore, the difference is now 23 providers.

CMS Response 7/7/22: We understand from the latest submission that there are now 160 providers participating. Is this number subject to change? Can the state also please discuss the reasoning for RHCs to opt out of the program – we understand some factors are uncertainty around the directed payment programs and the costs outweighing the gains in terms of participation.

State Round 4 Response: Yes, 160 RHCs are now participating in the program. This number should not change again. RHCs may always choose to decline payments, but they would still be included in the total originally enrolled. CMS is correct that while the state is not always certain why an RHC may choose ultimately to not participate, we understand that providers are concerned about the certainty of whether the program will be approved due to the delays in the prior year's program approval as well as concerns about whether the costs to comply with the conditions of participation of the program exceed the financial benefit of the increased claims.

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: 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.

CMS Response (5/11/22): Can the state please provide an update as to when CMS will receive this information?

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: We note the following changes for the uniform increases, can the state please confirm this is correct and provide a brief explanation as to what factors contributed to the changes.

	SFY 2022	SFY 2023	**SFY 2023 as of June 3, 2022**	**SFY 2023 as of June 22, 2022**
Component 1 (uniform dollar increase for freestanding rural health clinics)	$22.53 per unit	$75.43 per unit	$75.47 per unit	$75.11 per unit
Component 1 (uniform dollar increase for hospital-based rural health clinics)	$20.74 per unit	$44.34 per unit	$44.33 per unit	$44.03 per unit
Component 2 for all rural health clinics (uniform percent increase)	3.77% per claim	10.74 % per claim	10.74% per claim	10.77% per claim

State Round 3 Response: Please note the additional column above, as the values have shifted slightly due to the 5 RHCs that opted out. There are numerous factors driving the change in pool size that work together in a complex manner, but caseload growth is the main driver of the growth in the program. The growth factors were applied to the Medicare gaps which were used to determined the pool size. A second major factor contributing to the increase is the average Medicare rate increased by 14% between SFY2022 and SFY2023 for participating providers. The magnitude of the change to the Medicare gap from the increase in Medicare rate varies based on the number of units for that RHC. There were also significant Medicaid unit/payment changes between SFY2022 and SFY2023 in some cases based on changes in network status, since all calculations are using in-network data only.

CMS Response 7/7/22:

i. We have added the revised uniform increases to the table over. We understand that the changes to the uniform increases are a result of missing data for 4 providers, 3 more RHCs qualifying, 1 RHC closing, and also added the proposed final trend factors. Please confirm. Are these increases subject to change?

ii. Attachment C, under (b) for Component 2 says, "These numbers are estimations but will be finalized in June.". Please remove this language if it is no longer relevant.

State Round 4 Response: Yes, that is correct. These increases are not subject to change. The language in Attachment C has been updated accordingly, and the attachment has been renamed with 07.07.2022 in the filename.

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: The RAPPS payments will be made in addition to the PPS rate payment required by 1902(bb).

CMS Response (5/11/22): Please clarify what the state means by $22.53 / $20.74 add-on per unit for Component 1; will each eligible provider receive a $22.53 / $20.74 payment for each service billed as T1015 and any office visit codes individually? Or does per unit mean something else? Please update the preprint accordingly.

State Round 2 Response: The dollar per unit increase is for each service billed as T1015 and any office visit code individually. The preprint Attachment C has been updated to specify this. HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. 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 (5/11/22): Please clarify what the state means by 3.77% increase per claim for Component 2; will each eligible provider a 3.77% increase for each service T0105 and any office visit codes individually? Please update the preprint accordingly.

State Round 2 Response: Yes, the percentage rate increase is for each service billed as T1015 and any office visit individually. The preprint Attachment C has been updated to specify this. HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. 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 (5/11/22): Please clarify – given the overlap in codes, is the 3.77% increase applied to payments including those under Component 1 or applied to payments absent Component 1 payments? Please update the preprint accordingly.

State Round 2 Response: The percentage rate increase is applied to the individual MCO-adjudicated claim, without the Component 1 payment included. The preprint Attachment C has been updated to specify this.

CMS Response (6/3/22): However, a distinction is that the Component 1 is a uniform dollar increase based on historical utilization and paid out as a monthly payment that is a separate payment outside of the negotiated rate between the plans and providers. Whereas Component 2 is a uniform percent increase applied to the negotiated rate between the plans and providers at the time of claims processing. Is this an accurate summation?

State Round 3 Response: Yes, that is an accurate summation.

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: 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.

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

   State Round 2 Response: As of May 14, 2022, 163 of the 198 providers that requested to participate in RAPPS qualified.

   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: 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: The RAPPS payments will be made in addition to the PPS rate payments. No wrap payment is paid to RHCs.

   CMS Response 6/3/22: Thank you for providing an analysis in Table 2. We have compared the analyses from SFY 2022 to SFY 2023 (see table below).

	Average Base Payment from Plan to Provider	Effect on Total Payment Level of SDP	Total Payment Level
SFY 2022 Hospital-based RHCs	84%	16%	100%
SFY 2023 Hospital-based RHCs	71.91%	28.09%	100%
SFY 2023 Hospital-based RHCs as of June 3, 2022	71.92%	28.08%	100%
SFY 2023 Hospital-based RHCs as of June 22, 2022	71.95%	28.05%	100%
SFY 2022 Freestanding RHCs	75.02%	25%	100%
SFY 2023 Freestanding RHCs	49.02%	50.98%	100%
SFY 2023 Freestanding RHCs as of June 3, 2022	49.00%	51.00%	100%
SFY 2023 Freestanding RHCs as of June 22, 2022	49.18%	50.82%	100%

   i. Can the state please clarify if the Table 2 provider payment analysis methodology changed from SFY 2022 to SFY 2023?

   ii. When comparing SFY 2022 to SFY 2023, we note that for both provider classes, the average base payment decreased and effect on total payment level of SDP increased. Can the state please discuss what is driving these changes and if the state has concerns about the managed care plans using the RAPPS SDP when negotiating their initial rates with the providers.

   State Round 3 Response: The methodology changed in that the Medicare gaps are now being inflated by the trend factors at the SDA, risk-group level. Because there are significantly fewer freestanding RHCs than hospital-based RHCs, changes in the rates for one freestanding RHC affect the payment levels more significantly than would a change

in rates for the hospital-based class. In SFY2023, there are 14 freestanding RHCs. One RHC contains 24% of the Medicaid payments, and had a Medicaid payment level of 38% in SFY23, compared to 55% in SFY22. This decrease is due to an increase in units, a 27% increase in the Medicare rate, and the magnitude of the trend factor.

CMS Response 7/7/22: We have updated the table above to reflect the revised provider payment analysis provided in the preprint submitted on June 22, 2022. Attachment D says, "Final numbers will be provided when available in June". Please remove this language if it is no longer relevant.

State Round 4 Response: The values in the table above are correct. The language in Attachment D has been updated accordingly, and the attachment has been renamed with 07.07.2022 at the end.

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: 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: 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: If necessary, the rates and rate certifications will be amended.

   b. And does the state expect to amend the rates or rate certifications as a result of the reconciliation for SFY 2023?
   State Response: If necessary, the rates and rate certifications will be amended.
   CMS Response (5/11/22): When does the state and its actuary expect to know if amendments are necessary, and what would necessitate an amendment?

   State Round 2 Response: After the reconciliation occurs, the actuary will compare, at the rate cell level, what the capitation rates would've been with the reconciled information to the current capitation rates.

   CMS Response (6/3/22): Could the state's actuary please explain what threshold will be used to determine if an amendment is necessary.

State Round 3 Response: At this point the state would like to avoid being too prescriptive in setting a threshold at which an amendment will be required. The state anticipates that our initial analysis will consider variations at the rate cell level within +/- the risk margin to not require an amendment. Additional consideration will have to be given to rate cells that are relatively small that may have larger % variations; however, a rate amendment may be insignificant in the aggregate for such cases for certain MCOs. In other words the analysis will include both an evaluation at the rate cell level and in the aggregate for each MCO to determine whether a rate amendment is necessary.

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: MCOs retain 2.5% for administration, 1.5% for STAR risk margin, 1.75% for STAR+PLUS and STAR Kids risk margin, and 1.75% for premium taxes.

   CMS Response (5/11/22): Can the state please clarify/confirm - we understand that the state directed payment is identified as a separate component of the PMPM capitation rates for each rate cell, and this amount also includes the non-benefit cost loads cited in the state's response.

   State Round 2 Response: The state confirms this response.

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

    State Response: Scorecards direct the MCOs to pay out the capitation received for component 1, , after accounting for MCO fees detailed in question 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: 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): Thank you for the state's responses to our questions, it seems that # 11 & 12 in the Round 1 responses do not quite to address the questions raised by CMS. Can the state provide any specifics regarding where the funding for the specific entities in the state's IGT entity list will be coming from?

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

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

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

CMS Response 7/7/22: We note that we continue to have concerns with any IGTs, used to fund these payments, that are derived from any source other than state or local tax revenue, state appropriated funds, or from organizations that do not have general taxing authority. We remain 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. 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: 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: 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): Please provide an updated list of IGT entities when it is available, as noted in the response to question #13.

    State Round 2 Response: HHSC anticipates finalizing capitated rates, which will incorporate the final revised rate increases and estimated payments in mid-June. 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): 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.

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: 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.

    CMS Response (5/11/22): Regarding the state's response to question #14 in the Round 1 responses, 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 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. CMS understands that the state is in the process of setting up an oversight group related to the financing mechanisms described in this state directed payment preprint. Please describe steps in the near-term that the state will use to effectively oversee how these program payments are funded by the state or local units of governments.

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

CMS Response (5/11/22): We appreciate the state's response to question #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. 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: To the extent that a governmental entity uses bonds or other debt instruments, the oversight provided by the Local Funds Monitoring team will ensure that such instruments are not derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share and that the governmental entity is not improperly utilizing federal funding as the source of the IGT used to fund the non-federal share. HHSC continues to monitor local funds, to ensure the permissibility of local funds. The state understands and agrees that it is our responsibility to ensure that funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51.

CMS Response (5/11/22): Regarding question #16, what particular oversight will there be, both from the oversight body and in the current time frame prior to the oversight body beginning their work, when looking at the use of bonds and other debt instruments to fund the non-federal share?

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

CMS Response (6/3/22): 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. 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: 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: 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: 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: 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: 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.

    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 7/7/22: 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

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

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

c. We also understood from our November 2021 discussion that for state-level measures using EQRO data covering CY 2021, preliminary data would be ready in August 2022 and final data in October 2022. Is this still the case?
State Response: Yes, this is still the case. HHSC is set to receive preliminary data from the EQRO in August 2022 and final data from the EQRO in October 2022. As included in the response above, the final Year 1 Evaluation Report will be published no later than February 2023.

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: 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.

24. **New CMS Question 7/7/22**: 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.