Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   September 1, 2024 - August 31, 2027
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* September 1, 2024
3. Identify the managed care program(s) to which this payment arrangement will apply:
   STAR+PLUS
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $1,750,000,000 per year for SFY25, SFY26 and SFY27
   a. Identify the estimated federal share of this state directed payment: $1,050,175,000
   b. Identify the estimated non-federal share of this state directed payment: $699,825,000

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

State Fiscal Years 2018, 2019, 2020, 2021, 2022, 2023, 2024

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☒ Payment Type Change
☐ Provider Type Change
☒ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

Texas proposes four capitated components with the following quality metrics for participating Nursing Facilities (NFs):

Component One (Hospital Partner Minimum Data Set (MDS) Measures)
- The total value of Component One will be equal to 44 percent of the Quality Incentive Payment Program (QIPP) funds. Component One will be open only to non-state government owned (NSGO) providers.
- Allocation of funds across qualifying non-state government-owned NFs will be proportional, based upon historical Medicaid days of nursing facility service.
- Quarterly payments to nursing facilities will be triggered by achievement of performance requirements for one or more Long-Stay Minimum Data Set (MDS) quality measures designated by HHSC. Achievement is measured against program-wide as well as facility-specific targets.

Component Two (Workforce Development)
- The total value of Component Two will be equal to 20 percent of the QIPP funds. Component Two will be open to all provider types.
- Allocation of funds across qualifying non-state government-owned and private nursing facilities will be proportional, based upon historical Medicaid days of nursing facility service.
- Quarterly payments to nursing facilities will be triggered by achievement of facility-specific or program-wide targets in one or more quality measures within the component.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

Nursing Facility Services are approved under the Medicaid state plan Appendix 1 to Attachment 3.1-A Page 5. Nursing Facility Services for Individuals 21 Years of Age or Older, located at https://apps.hhs.texas.gov/documents/medicaid-chip-state-plan-attachments.pdf. CMS approved the 1115 waiver renewal for the Texas Healthcare Transformation and Quality Improvement Program, which includes Nursing Facility services provided through managed care, on January 15, 2021.

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☐ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☒ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

The Quality Incentive Payment Program (QIPP) is designed to provide incentive payments to nursing facilities based on making improvements on specific quality indicators or reaching program-wide benchmarks.
Nursing facilities participating in QIPP earn payment for demonstrating improvement in measures that keep patients free from harm; promote effective practices for people with chronic, complex, and serious conditions; and reward providers for participating in team-based, collaborative, and coordinated care.
QIPP will include four components. All components are value-based, with pay-for-performance tied to key measures.
Component One includes five quality metrics related to care that can be improved by better coordination with hospitals; achievement in one metric will earn 90% of available component funds, and achievement in two or more metrics will earn 100% of funds.
Component Two includes three quality metrics related to workforce development. Metrics are weighted differently in each year of the three-year proposal:
• For program periods beginning on September 1, 2024, achievement in 1 metric earns 70 percent and achievement in 2 or more metrics earns 100 percent of total dollars included in the component;
• For program periods beginning on September 1, 2025, achievement in 1 metric earns 60 percent, achievement in 2 metrics earns 85 percent, and achievement in 3 metrics earns 100 percent of total dollars included in the component; and
• For program periods beginning on or after September 1, 2026, each quality metric will be allocated an equal portion of the total dollars included in the component.
Components Three and Four include up to three quality metrics each. Component Three measures have been designated a priority based on current state performance and component four metrics focus on quality of care for nursing facility residents. The quality metrics will be equally weighted (within a component) for payment each quarter.

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☒

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

Components 1, 3, and 4: NF-specific performance targets for MDS-based performance measures were set at 5% relative improvement each quarter based on successes in previous program years related to MDS improvement. In SFY 2018 and SFY 2019, the "strong improvement" target included 5% relative improvement each quarter. Starting with SFY 2020, this was adopted as the standard improvement target across MDS-based performance measures.
For Component 3, program-wide performance targets are set at the national average. NFs achieve a measure for Quarter 1 if: 1) the NF has 5% relative improvement on the NF-specific baseline; or 2) the NF meets or exceeds the program-wide benchmark (the most recently published national average at the beginning of the program period). NFs achieve a measure for Quarter 2 if: 1) the NF has 10% relative improvement on baseline; or 2) the NF meets or exceeds the program-wide benchmark. NFs achieve a measure for Quarter 3 if: 1) the NF has 15% relative improvement on baseline; or 2) the NF meets or exceeds the program-wide benchmark. NFs achieve a measure for Quarter 4 if: 1) the NF has 20% relative improvement on baseline; or 2) the NF meets or exceeds the program-wide benchmark.
For Components 1 and 4, where the Texas average is better than the national average, program-wide targets are set at the Texas average. NFs achieve the measure for Quarter 1 if: 1) the NF has 5% relative improvement on the NF-specific baseline; or 2) the NF meets or exceeds the program-wide benchmark (the most recently published Texas average at the beginning of the program period). NFs achieve the measure for Quarter 2 if: 1) the NF has 10% relative improvement on baseline; or 2) the NF meets or exceeds the program-wide benchmark. NFs achieve the measure for Quarter 3 if: 1) the NF has 15% relative improvement on baseline; or 2) the NF meets or exceeds the program-wide benchmark. NFs achieve the measure for Quarter 4 if: 1) the NF has 20% relative improvement on baseline; or 2) the NF meets or exceeds the program-wide benchmark.
Component 2: NF-specific performance targets for staffing ratio Hours Per Resident Day (HPRD) performance measures are set at 1% relative improvement each quarter. Program-wide performance targets are set at the national average. NFs achieve the measure for Quarter 1 if: 1) the NF has 1% relative improvement on the NF-specific baseline; or 2) the NF meets or exceeds the program-wide benchmark (the most recently published national average at the beginning of the program period). NFs achieve the measure for Quarter 2 if: 1) the NF has 2% relative improvement on baseline; or 2) the NF meets or exceeds the program-wide benchmark. NFs achieve the measure for Quarter 3 if: 1) the NF has 3% relative improvement on baseline; or 2) the NF meets or exceeds the program-wide benchmark. NFs achieve the measure for Quarter 4 if: 1) the NF has 4% relative improvement on baseline; or 2) the NF meets or exceeds the program-wide benchmark.
To account for natural fluctuations in quarterly performance results while still holding NFs accountable for incremental improvement, the state will define an allowed margin for each quality metric. Any metric will be considered "Not Met" for the quarter if a NF performs worse than its initial baseline by more than this margin. Each metric's margin will be defined as an absolute 2% shift from the facility baseline.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

For Component 1: Achievement in one metric will earn 90% of available component funds, and achievement in two or more metrics will earn 100% of funds.
For Component 2: Achievement will be weighted differently in each year of the three-year proposal:
• For program periods beginning on September 1, 2024, achievement in 1 metric earns 70 percent and achievement in 2 or more metrics earns 100 percent of total dollars included in the component;
• For program periods beginning on September 1, 2025, achievement in 1 metric earns 60 percent, achievement in 2 metrics earns 85 percent, and achievement in 3 metrics earns 100 percent of total dollars included in the component; and
• For program periods beginning on or after September 1, 2026, each quality metric will be allocated an equal portion of the total dollars included in the component.
For Components 3 and 4: Performance measures are equally weighted within a Component. If the provider meets performance targets for all measures within a Component, they will receive all available funds related to that Component. For example, if the provider meets only one out of three measures in a Component, they will receive only one-third of their available funds related to that Component.

c. For state-developed measures, please briefly describe how the measure was developed?

HHSC proposes using only nationally recognized, pre-existing quality measures for SFY 2025.

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☒ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

The state is seeking a three-year approval for state fiscal years 2025, 2026 and 2027 (9/1/2024 to 8/31/2027).

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☐ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☒ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Non-state government-owned nursing facilities and private nursing facilities

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Non-state government-owned NF--A network nursing facility where a non-state governmental entity located in the state of Texas holds the license and is a party to the NF's Medicaid provider enrollment agreement with the state.

Private NF--A network nursing facility not owned by a governmental entity that is located in the state of Texas and which holds a license.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

Prior to the beginning of the program period, HHSC identifies funds associated with each QIPP-enrolled NF broken down by QIPP capitation rate component, quality metric, and payment period. Cost report historical units of service are used to determine the distribution of QIPP funds across eligible and enrolled NFs. The NF must have had at least one Medicaid client in the care of that NF for each reporting period to be eligible for payments. In situations where a NF does not have enough data for a quality metric to be calculated, the funding associated with that metric will be evenly distributed across all remaining metrics within the component. HHSC will specify the performance requirement that will be associated with the designated quality metric. Achievement of performance requirements will trigger payments for the QIPP capitation rate components. Funds that are non-disbursed due to the failure of one or more NFs to meet performance requirements will be distributed across QIPP NFs who have demonstrated achievement of a measure designated by HHSC. Non-disbursed funds distributed across NFs will be allocated to each achieving NF based upon each NF's proportion of total earned QIPP funds from Components One, Two, Three, and Four combined compared to the total amount paid to achieving NFs from all components.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☐

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Public NF	48.05%	17.70%	0.00%	N/A	65.75
b. Private NF	48.59%	6.06	0.00%	N/A	54.66
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☒ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The Average Base Payment Level from Plans to Provider represents the average Medicaid per diem paid from plans to the provider as a percent of the average Medicare per diem equivalent. The state reported both per diem amounts on the FY2023 CMS NF UPL Demonstration, columns 315 and 400 respectively. The Effect on Total Payment Level of State Directed Payment represents the estimated SFY25 QIPP per diem payments to all participants as a percent of the same Medicare per diem referenced in the Average Base Payment Level from Plans to Provider column. The Total Payment Level represents the sum of Medicaid and QIPP per diem amounts as a percent of the same Medicare per diem referenced in the Average Base Payment Level from Plans to Provider column.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

To ensure that QIPP funds are focused on the Medicaid population, HHSC will limit private nursing facility eligibility to nursing facilities with a percentage of Medicaid nursing facility days of service greater than or equal to 65 percent. The payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers providing the service under the contract. Payments of allocated funds will be triggered based on either the attainment of benchmarks or demonstrated improvement in selected quality metrics. Non-dispersed funds due to an NF's failure to achieve a metric will be distributed across QIPP NFs who have demonstrated achievement of a measure designated by HHSC.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☒ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

HHSC will provide the managed care contracts 45 days prior to the effective date of the contracts.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☒ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

07/18/2024

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

N/A

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

a. ☒ An adjustment applied in the development of the monthly base capitation rates paid to plans.

b. ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.

c. ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

N/A

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

a. ☐ State general revenue

b. ☒ Intergovernmental transfers (IGTs) from a State or local government entity

c. ☐ Health Care-Related Provider tax(es) / assessment(s)

d. ☐ Provider donation(s)

e. ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☒

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

There are no written agreements between HHSC and healthcare providers participating in QIPP regarding QIPP. The state currently collects information from units of local government that provide IGTs to the state to ensure compliance with all federal regulations. Texas began to implement large-scale monitoring of the non-federal share in state fiscal years 2022 and 2023. Texas continues to refine its monitoring mechanisms as the monitoring program matures.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. N/A						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. N/A			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficie
- **b.** The effective date of quality strategy. September 9, 2021

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Please refer to Addendum Table 7.A		
b.		
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

Through the QIPP program, the state aims to
A. Keep patients free from harm by building a safer healthcare system that limits human error;
B. Promote effective practices for people with chronic, complex and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of healthcare costs; and
C. Attract and retain high-performing Medicaid providers to participate in team-based, collaborative, and coordinated care. Providers earn payments by meeting performance requirements in four components:
● Component One: Texas Hospital Partner Minimum Data Set (MDS) CMS Quality Measures
● Component Two: Workforce Development
● Component Three: Texas Special Focus MDS CMS Quality Measures
● Component Four: Resident Focus MDS CMS Quality Measures
All components are structured as pay-for-performance and include nationally recognized quality measures. A three-year plan will give nursing facilities more certainty in the quality priorities through SFY2027, allowing them to better direct their resources toward meeting the quality objectives of the program.
Component Two: Research demonstrates that additional staff coverage enhances quality of care, including patient safety. As the program is using new staffing measures in SFY2025, the requirements for staffing ramp up over the course of the three-year plan, with all three staffing measures having to be met in SFY2027 to earn full payment for the component.
Components One, Three, and Four: QIPP will help keep members free from harm and improve practices for members with chronic, complex, and serious conditions through quality metrics relating to ten Minimum Data Set CMS Long-Stay Quality Measures. NFs can contribute to these goals by meeting or exceeding program-wide targets or by showing an improvement in their baselines for
• falls with major injury (CMS N013.2),
• pressure ulcers (CMS N045.01),
• catheter left in bladder (CMS N026.03),
• weight loss (CMS N029.03),
• depressive symptoms (CMS N030.03),
• antipsychotic medication (CMS N031.04),
• mobility (CMS N035.04),
• antianxiety or hypnotic medication (CMS N036.03),
• UTIs (CMS N024.02), and
• bowel or bladder incontinence (CMS N046.01)
Over the course of the three-year quality plan, the achievement for targets for nursing facilities will increase when the performance target is met or exceeded. This is expected to incentivize nursing facilities with below-average performance to improve continuously, closing gaps in the availability of high-quality care for STAR+PLUS members.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. See Attachment A for the Evaluation Plan. Note: The information requested in Table 8 is contained in Table 5 of Attachment A.				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

See Attachment B for the SFY2022 - 2024 evaluation results. The evaluation includes final performance data for SFY2022 and SFY2023, and partial data for SFY2024. Data for SFY2024 will be included in next year's evaluation report.