House Human Services Committee – Interim Charge 2

Interim Charge 2: *Review how Texas is preparing for state and federal budgetary changes that impact the state's health programs, including: the Family First Prevention Services Act; the next phase of the 1115 Healthcare Transformation and Quality Improvement Program Waiver; Texas' Targeted Opioid Response Grant; the Centers for Medicare and Medicaid Services proposed Medicaid Fiscal Accountability rule, and the Healthy Texas Women Section 1115 Demonstration Waiver.*

2.2: 1115 HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM WAIVER

Overview

In 2011, Senate Bill (SB) 7, 82nd Legislature, First Called Session, directed HHSC to preserve federal hospital funding historically received as supplemental payments under the upper payment level (UPL) program. UPL payments were supplemental payments made to offset the difference between what Medicaid pays for a service and what Medicare would pay for the same service. House Bill (HB) 1, 82nd Legislature, Regular Session, 2011, and Senate Bill (SB) 7, 82nd Legislature, First Called Session, 2011, also instructed HHSC to expand its use of Medicaid managed care.

Federal regulations issued by the Centers for Medicare and Medicaid Services (CMS) prohibit UPL payments to providers in managed care. Therefore, CMS advised the Health and Human Services Commission (HHSC) that, to continue the use of local funding to support supplemental payments to providers in managed care, the state should employ a waiver of the Medicaid state plan as provided by Section 1115 of the Social Security Act.

Accordingly, on July 15, 2011, HHSC submitted a proposal to CMS for a five-year Section 1115 demonstration waiver designed to build on existing Texas healthcare reforms and to redesign health care delivery in Texas consistent with CMS goals to improve the experience of care, improve population health, and reduce the cost of

health care without compromising quality. CMS approved the Section 1115 Transformation Waiver on December 12, 2011. In December 2017, CMS approved a five-year extension of the waiver through September 30, 2022.[1]

The Texas 1115 Transformation Waiver provides the federal authority for operations of most of the state's Medicaid managed care programs, including STAR, STAR+PLUS, STAR Kids, and the Children's Dental Program. Managed care directed payment programs—the Uniform Hospital Rate Increase Program (UHRIP) and the Quality Incentive Payment Program (QIPP)—both operate within the 1115 waiver under authority conferred in 42 Code of Federal Regulations (CFR) 438.6(c). These programs provide additional funding to hospitals and nursing homes through increases in managed care reimbursement for hospital and nursing home services.

A third managed care program, the Network Access Improvement Program (NAIP), provides pass-through payments to participating physician practices in health-related institutions and public hospitals through managed care. NAIP operates within the 1115 waiver under authority conferred in 42 CFR 438.6(d). Under federal law, pass-through payments to physicians must be phased out by July 1, 2022, and pass-through payments to hospitals must be phased out by July 1, 2027.

The non-federal share of each of these managed care directed payment programs is provided by local governmental entities.

The 1115 waiver also contains two funding pools: the Uncompensated Care (UC) and the Delivery System Reform Incentive Payment (DSRIP) pools.

For the first five years of the waiver, which began in State Fiscal Year 2012, combined UC and DSRIP funding totaled $29 billion All Funds (AF), with $17.6 billion allocated for UC and $11.4 billion allocated for DSRIP. For the first 2 years of the extension, the UC pool was $3.1 billion and $3.87 billion AF each year thereafter. This year, the DSRIP pool is $2.91 billion AF. However, in Federal Fiscal Year (FFY) 2021, the pool will be reduced to $2.49 billion, and the following FFY, to zero.

[1] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83231

	UC Pool (in billions)	DSRIP Pool (in billions)
FFY 2012	$3.70	$0.50
FFY 2013	$3.90	$2.30
FFY 2014	$3.53	$2.67
FFY 2015	$3.35	$2.85
FFY 2016	$3.10	$3.10
FFY 2017	$3.10	$3.10
FFY 2018	$3.10	$3.10
FFY 2019	$3.10	$3.10
FFY 2020	$3.87	$2.91
FFY 2021	$3.87	$2.49
FFY 2022	$3.87	$0

For each program, the non-federal share is provided by local governmental entities. In order to receive UC or DSRIP payments, providers must participate in one of the twenty Regional Health Partnerships (RHPs).

Uncompensated Care

UC payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. Though previously defined as unreimbursed costs for Medicaid and uninsured patients incurred by hospitals, UC costs are currently federally defined as unreimbursed charity care costs. UC payments are based on each provider's uncompensated care costs as reported to the state on a UC application.

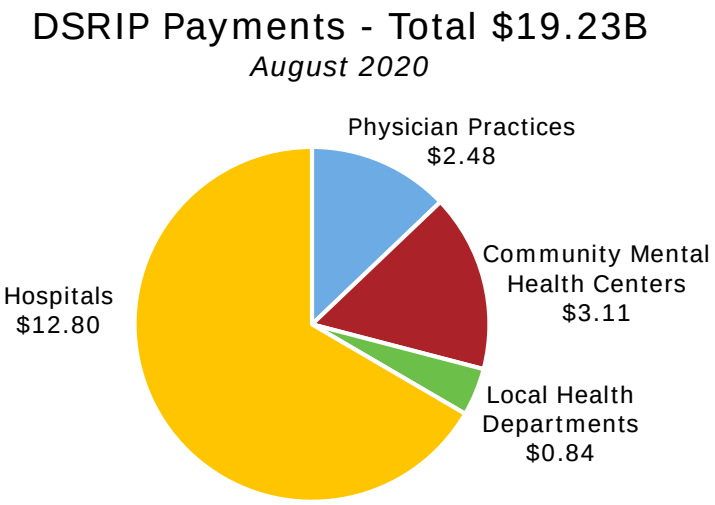
Delivery System Reform Incentive Payment

The DSRIP program provides incentive payments to participating providers to improve health outcomes. Providers develop and implement programs, strategies, and investments to enhance:

- Access to healthcare services
- Quality of health care and health systems
- Cost-effectiveness of services and health systems
- Health of the patients and families served

There are currently 290 participating DSRIP providers, including hospitals, community mental health centers (CMHCs), physician groups primarily associated with academic health science centers, and local health departments (LHDs). The

participating providers have earned over $19.23 billion in DSRIP funds from 2012 to August 2020.



DSRIP providers have served 11.7 million people and provided 29.4 million encounters from October 1, 2013 to September 30, 2017, primarily to the Medicaid, low-income, and uninsured populations.[2] Participating providers have demonstrated success in increasing access to care and improving quality measurements. HHSC must report on the outcomes achieved by DSRIP providers by December 1, 2020, in accordance with the 2020-21 General Appropriations Act, HB 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 38).

CMS considers DSRIP programs to be time limited. Some other states have 1115 Waivers, including DSRIP-like programs, that are not being extended by CMS.

The 1115 waiver required HHSC to submit a DSRIP Transition Plan to describe how the state will further develop its delivery system reform efforts when DSRIP funding ends on September 30, 2021.[3] In September 2019, HHSC submitted a draft DSRIP Transition Plan to CMS (see Appendix A). The milestones included in the transition plan lay the groundwork to develop strategies, programs, and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care. HHSC is at risk for federal financial participation in the current DSRIP program if it does not meet the milestone deliverable due dates. CMS has approved HHSC's

[2] The numbers of people served, and encounters provided are for FFYs 2014-2017 and are not unduplicated counts.
[3] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-transition-plan.pdf

requested changes to milestone deliverable deadlines due to impacts of COVID-19 and provided formal approval of the transition plan on September 2, 2020.

The DSRIP Transition Plan seeks to sustain funding to continue healthcare transformation and advance value-based payments (VBP). To achieve these goals, HHSC is considering options such as policy changes, targeted benefits, and managed care directed payments to support DSRIP providers and their traditional activities. However, many DSRIP providers serve uninsured individuals through DSRIP. While directed payments can be used to increase or target reimbursement for services provided to Medicaid recipients, federal Medicaid managed care funds cannot be used for programs for the uninsured.

HHSC must also holistically consider Medicaid payments to providers. CMS requires that managed care capitation rates, including directed payment rates, be consistent with the established reimbursement principles that payments should be economic and efficient. Typically, CMS has used an external benchmark like Medicare or average commercial reimbursement as a tool to analyze whether Medicaid rates are "reasonable."

Lastly, COVID-19 response has significantly changed how health care is delivered, which must now be considered in determining how to further develop, sustain, and measure outcomes for effective delivery system reforms for DSRIP transition.

Budget Neutrality

Under federal budget neutrality requirements, a state may not spend more Medicaid dollars under an 1115 Waiver than it would have spent without that waiver. Using the CMS methodology in place during the first five years of the waiver, combined Medicaid managed care spending, and spending for the two waiver pools, was roughly $8 billion less than the state would have spent without the waiver. This was a result of the federal government's estimate of fee-for-service costs, caseload, and health care cost trend (without waiver) compared with actual state managed care costs per member per month (PMPM) (with waiver). During the five years of the waiver extension, the federal trend estimate (called the President's trend) averages 4.5 percent overall versus the state's most recent 5-year managed care trends of between 3 percent and 4 percent. The difference has helped create the budget neutrality room used for the UC and DSRIP pools.

Budget neutrality room also allows funding space for the state to add to existing programs, or create new ones, such as DSRIP replacements.

In 2016, CMS changed the policy regarding the calculation of budget neutrality for 1115 Waiver extensions. The policy changes were described in detail in State

Medicaid Director Letter 18-009 of August 22, 2018 and apply to any 1115 Waiver extensions requested after January 1, 2021.[4]

CMS made two key changes to the budget neutrality calculation. First, CMS will only allow states to roll over savings from the most recently-approved five years of the waiver. Second, CMS will rebase the without waiver PMPM baselines to match actual PMPM expenditures experienced during the prior demonstration approval period. HHSC expects these changes to have material impacts on the budget neutrality room available in the extension.

According to the Special Terms and Conditions (STCs) of the current 1115 Waiver, if the annual assessment of budget neutrality indicates that the annual target has been exceeded, or is projected to be exceeded, HHSC must propose adjustments to the limits to the UC and DSRIP pools.

Next Steps

HHSC will develop a project plan and timeline to determine whether we will submit an application to CMS to request an extension of the 1115 Waiver or whether we will explore other federal authority to continue the transformation of the Medicaid program. The plan will contemplate opportunities for stakeholder engagement over several months and during the legislative session. The goal would be to submit necessary requests to CMS by September 30, 2021, at least 12 months before the waiver ends on September 30, 2022.

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf

2.3: TEXAS TARGETED OPIOID RESPONSE PROGRAM

Overview

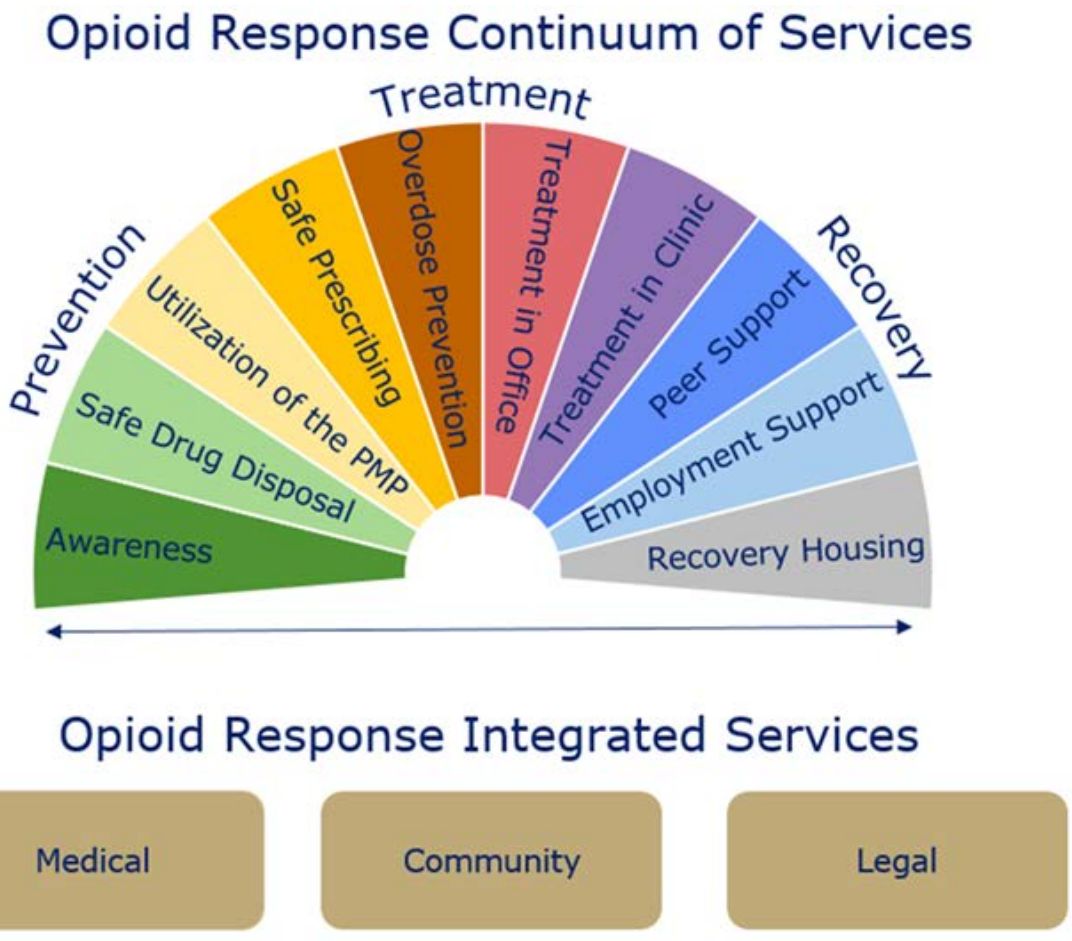
HHSC implements federal awards to address the opioid crisis in Texas through the Texas Targeted Opioid Response (TTOR) Program, which was created in May 2017 when the federal Substance Abuse and Mental Health Services Administration (SAMHSA) initially awarded State Targeted Response (STR) funds in the amount of $27.4 million.

On September 19, 2018, SAMHSA awarded Texas $46.2 million in State Opioid Response (SOR) funds to extend and expand HHSC's response to the opioid crisis. On May 6, 2019, the state received a $24.1 million supplemental award under this grant. On August 27, 2020, SAMHSA awarded $52.1 million in State Opioid Response 2020 (SOR20) funds to continue these services.

SAMHSA also awarded HHSC two smaller discretionary grants in 2016 and 2017 targeting opioid use. Services provided with these funds are coordinated with the SOR and STR funds to maximize services without duplication.

- The Texas Strategic Prevention Framework for Prescription Drugs (SPF-Rx) is a five-year grant in the amount of $1,858,080 aimed at raising awareness about the risks of overprescribing to young adults and bringing prescription misuse prevention activities and education to schools, communities, and parents.
- The Texas First Responders - Comprehensive Addiction and Recovery Act (FR-CARA) grant is a four-year grant in the amount of $3.2 million. The goal of this collaborative project is to reduce opioid overdose related mortality rates, strengthen the successfulness of first response to overdose, and coordinate care for overdose survivors in Bexar County.

The TTOR program aims to address the opioid crisis by reducing unmet treatment needs and opioid overdose-related deaths through prevention, treatment, and recovery activities.



Eligibility Requirements

Type of Service	Population
Prevention	General public
Treatment	Persons with opioid use disorder who meet the financial and clinical eligibility requirement
Recovery	Persons with a history of opioid use
Integrated	Persons at risk for opioid overdose and their support systems

Location

Prevention		
Strategy	*Description*	*Location*
Awareness	Provide services to Texans across the lifespan to enhance social and emotional skills, increase knowledge about opioid misuse-related dangers, and aid in finding help for opioid use disorder.	Statewide education
Safe Drug Disposal	Funds safe drug disposal initiatives such as drug take back events, drug drop-boxes, and single-use drug disposal pouches.	Statewide distribution to prevention coalitions
Prescription Monitoring Program	The goal of this project is to increase prescriber and pharmacist enrollment and meaningful use of the Prescription Monitoring Program to ensure not only patient screening but identification of problematic opioid use and appropriate referral to treatment.	Statewide support at www.txpmp.org
Safe Prescribing	This project supports prescriber education and online training aimed at reducing opioid misuse through safe prescribing practices.	Statewide support at http://sites.utexas.edu/naloxone/
Overdose Prevention	This project supports overdose prevention education, access to overdose reversal medication (naloxone), and overdose reversal tracking tools.	Statewide distribution through www.morenarcanplease.com

Treatment		
Strategy	*Description*	*Location*
Treatment (outside of clinic)	This project increases access to medication assisted treatment (MAT) in a variety of settings outside of the traditional clinic by increasing the number of physicians providing both buprenorphine and extended release naltrexone, expanding opportunities for physicians to obtain DATA 2000 Waiver training, creating a professional peer mentoring network, and expanding the network of state-funded treatment providers.	8 Local Mental Health Authorities; UT Health in process of enrolling new locations statewide
Treatment (within clinic)	This project increases access to all three U.S. Food and Drug Administration-approved medications for the treatment of opioid use disorder (methadone, buprenorphine, and extended release naltrexone) by expanding capacity at new and existing clinics. This will enable clinics to treat both primary opioid use disorder along with co-morbid conditions such as hepatitis C, psychiatric conditions, and wound care at a single clinic site.	Approximately 35 clinics across the state

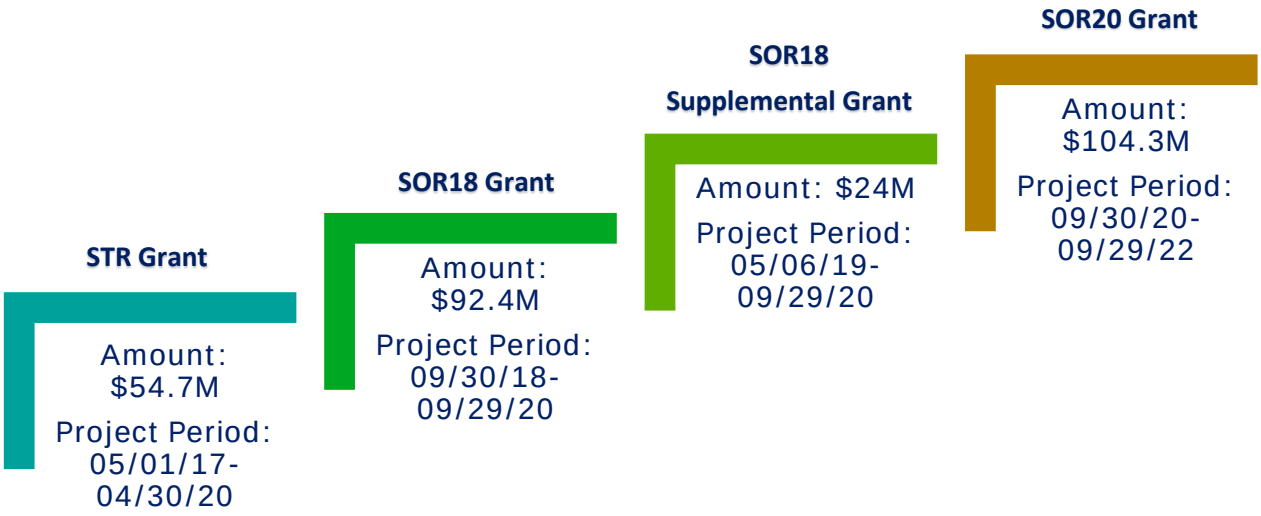
Recovery		
Strategy	*Description*	*Location*
Peer Support	This project expands peer recovery support services throughout the state in a variety of settings and provides opportunities for enhanced training in medication assisted recovery for the peer support workforce.	Approximately 50 throughout the state
Employment Support	This project provides job developer and supported employment services for individuals in medication assisted recovery from opioid use disorders as well as support to the emergency services personnel referral program.	6 programs in San Antonio, El Paso, the Rio Grande Valley, Central Texas, and East Texas
Recovery Housing	This project provides resources to increase safe housing and eliminate discriminatory barriers for individuals in medication assisted recovery from opioid use disorder.	Locations to be established serving large metro areas, rural, border, and tribal communities

Integrated		
Strategy	*Description*	*Location*
Medical	Serves people at high risk for overdose and overdose survivors to ensure they receive treatment induction, recovery support, community medical support, and overdose prevention services.	Programs currently in Bexar, Williamson, and Harris counties and adding nine additional sites throughout the state
Community	Enhances access to treatment, recovery support, overdose prevention, and linkage to care through Outreach, Screening, Assessment, & Referral (OSAR) services, Mobile Crisis Outreach Teams (MCOT), and 24/7 overdose prevention community drop-in sites.	OSAR services located at 14 LMHAs covering all 11 health service regions; 5 MCOT teams in central Texas, north Texas, and southeast Texas; and a community drop in site in Travis County
Legal	Provides 24/7 overdose prevention pre-arrest diversion services located within sobering centers. Services include treatment induction, recovery support, overdose prevention, and linkage to care. This project also supports people about to be released from incarceration by providing pre-release medication assisted treatment, linkage to on-going treatment, peer recovery support, and overdose prevention services.	Drop-in sites located in Bexar, El Paso, and Harris counties, reentry located in Harris, Tarrant, and Rio Grande Valley area, prison reentry location will serve inmates throughout the state

Contracts

As of September 2020, TTOR has 85 contracts (some contractors may provide services at multiple sites).

Funding



The SOR20 grant is a decrease of a little more than 10 percent in funding from the previous award when coupled with the supplemental award. The reduction is the result of SAMHSA revising its funding methodology; they now utilize a 15 percent set-aside for the 10 states with the highest mortality rates due to drug poisoning deaths. HHSC does not anticipate an impact to its program due to the decreased funding. A request was submitted to SAHMSA in July 2020 to carryover unexpended funds that remained at the end of federal fiscal year 2020. The request is for $10.4 million, and we expect receive notice from SAMHSA in October 2020.

Additional Federal Funding

Federal Grant Award	Annual Funding	Funding Period
Strategic Prevention Framework for Prescription Drugs (SPF RX)*	$371,616	September 1, 2019-August 31, 2020
First Responders-Comprehensive Addiction and Recovery Act (FR-CARA)**	$800,000	September 30, 2019-September 29, 2020

*SPF-Rx is five-year grant (9/1/2016-8/31/2021)
**FR-CARA is a four-year grant (9/30/2017-9/29/2021)

Key Deliverables (as of April 2020)

- **Prevention Services**
  - 129,097 people have participated in opioid misuse prevention activities. The Substance Abuse Prevention and Treatment Block Grant began sustaining these activities September 2018.
  - 6,052 individuals have received overdose prevention training.
  - 229,864 medication disposal pouches have been distributed.
  - 3,791 medical and behavioral health professionals have received overdose prevention online continuation education.
  - 23,276 pounds of prescription drugs were disposed.
  - More than 295,351 naloxone kits (each containing two 2mg doses) have been distributed.
- **Treatment Services**
  - 8,096 individuals have received medication-assisted treatment; (4,879 with STR funding and 3,217 with SOR funding).
  - The table below reflects the breakout of opioid use disorder (OUD) medications administered.

FDA-approved Medications	Number of STR funded Clients	# of SOR funded Clients	Total
Methadone	3,745	2,498	6,343
Buprenorphine	1,106	690	1,796
Naltrexone	28	29	57
Total clients receiving MAT	4,879	3,217	8,096

  - 3,082 health screening, testing, and treatment for comorbid conditions made available to individuals receiving medication-assisted treatment.
- **Recovery Support Services**
  - 9,403 individuals with OUD have received peer recovery coaching services as of March 31, 2020.
  - 1,855 individuals have enrolled in long-term Recovery Coaching.
  - 227 individuals with OUD have been authorized to receive employment services.
  - 80 individuals with a history of opioid use have received recovery support services including overdose prevention services prior to and upon release from jail.
  - 398 individuals with OUD have entered recovery housing as of March 31,2020.
- **Integrated Services**
  - 1,200 individuals have received overdose-related emergency response services.

    - 475 individuals with OUD have received overdose-related services through MCOTs.
    - 1,172 individuals with OUD have accessed treatment services through OSAR Priority Admission Counselors within three days of screening.
- As of May 31, 2020, through evidence-based strategies implemented with TTOR funding, HHSC has seen an increase in the proportion of people served in evidence-based treatment for OUD from 16 percent to 63.23 percent.

2.4: MEDICAID FISCAL ACCOUNTABILITY RULE

HHSC submitted comments on CMS' proposed Medicaid Fiscal Accountability Rule on January 31, 2020. The comments are included in Appendix B.

On September 14, 2020, CMS issued a statement that due to "potential unintended consequences of the proposed rules" further study is required and therefore, "CMS was withdrawing the rule from the regulatory agenda."

2.5: HEALTHY TEXAS WOMEN SECTION 1115 DEMONSTRATION WAIVER

Overview

The Healthy Texas Women program (HTW) offers free women's health and family planning services to eligible, low-income women. These services help women plan their families, whether they want to achieve, postpone or prevent pregnancy. Health services offered through HTW include:

- Contraceptive services, including long-acting reversible contraception
- Clinical breast exams
- Pregnancy testing and counseling
- Preconception health screenings (e.g., screening for obesity, hypertension, diabetes, cholesterol, smoking and mental health)
- Sexually transmitted infection services
- Sterilizations
- Treatment for the following chronic conditions:
  - Hypertension
  - Diabetes
  - High cholesterol
- Treatment of postpartum depression
- Breast and cervical cancer screening and diagnostic services
  - Radiological procedures, including mammograms
  - Screening and diagnosis of breast cancer
  - Diagnosis and treatment of cervical dysplasia
- Immunizations

HTW services are delivered by a statewide network of fee-for-service providers. To be reimbursed for HTW services, providers must:

- Deliver the types of services available through the program.
- Have completed the Medicaid enrollment process through the Texas Medicaid & Healthcare Partnership.
- Certify that they do not perform or promote elective abortions or affiliate with an entity that performs or promotes elective abortions.

Historically, HTW was funded through state general revenue.

1115 Waiver Demonstration

HHSC submitted the HTW Section 1115 Demonstration Waiver application to CMS on June 30, 2017. Through the HTW demonstration, HHSC seeks to enhance

women's health care services by increasing access to and participation in the HTW program. The goals and objectives of the HTW demonstration are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection.
- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.
- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective services consistent with these goals.

HHSC received CMS approval for the HTW 1115 demonstration waiver on January 22, 2020. Client benefits and provider requirements did not change as a result of federal approval. Under the demonstration, services may be delivered to eligible women ages 18-44. Young adults ages 15-17 may still receive the same benefit package, with parental consent. Due to federal restrictions, HTW services for young adults are not eligible for federal matching funds and are provided through general revenue funds.

As a condition of federal approval, HHSC must comply with federal Medicaid eligibility, application, verification, and demonstration regulations. Effective February 18, 2020, clients are provided 95 days (referred to as reasonable opportunity) to provide verification of citizenship or immigration status at initial application if they declare themselves to be U.S. citizens or declare to have an eligible immigration status. Verification is only required at renewal if there was a change in citizenship or immigration status. If all other eligibility requirements are met besides citizenship or immigration status, an individual is eligible for HTW during the reasonable opportunity period.

In addition, by July 2021, HHSC must use Modified Adjusted Gross Income (MAGI) methodologies to determine household composition and countable income, and the HTW Federal Poverty Level (FPL) threshold will be converted to a MAGI equivalent. As a result of the requirement to use MAGI methodologies, women eligible for

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Supplemental Nutrition Assistance Program (SNAP), or who have a child eligible for Medicaid will no longer be automatically financially eligible for HTW. Women will be determined ineligible for full Medicaid and CHIP before being determined eligible for HTW.

CMS also requires a waiver implementation plan addressing a variety of topics, including how HHSC will monitor access to care, the adequacy of the provider network, inquiries, and complaints. HHSC is working with CMS to obtain approval of an implementation plan, which will be posted to HHSC's website and become an attachment to the federal waiver once approved.

As a result of federal approval, HTW is now funded through both federal and general revenue funds. HHSC receives federal funds at a 90 percent match rate for family planning services and approximately 60 percent[5] match rate for all other services in the approved waiver for the approved population. The change in method of finance provides Texas significant general revenue savings for the program.

Healthy Texas Women Plus

As required by SB 750, 86th Legislature, Regular Session, 2019, HHSC evaluated postpartum care services provided to women enrolled in the HTW program after the first 60 days of the postpartum period. Based on the evaluation, HHSC developed an enhanced, cost-effective, and limited postpartum care services package for women enrolled in the HTW program to be provided:

- after the first 60 days of the postpartum period and;
- for a period of not more than 12 months after the date of enrollment in the HTW program.

The 2020-21 General Appropriations Act, HB 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 176) appropriated $13,643,638 in general revenue

[5] Non-family planning services are matched at the state's federal medical assistance percentage (FMAP). CMS updates the FMAP rate annually based on each state's average per capita income. For federal fiscal year (FFY) 2020, Texas' Medicaid FMAP is 60.89 percent. Texas uses a one-month differential FMAP figure that takes into account differences between the FFY (October through September) and the state fiscal year (SFY) (September through August). The one-month differential FMAP for Texas in SFY 2019 is 60.67%. This includes one month of the FFY 2019 rate and 11 months of the FFY 2020 rate. The 6.2% stimulus FMAP bump is excluded from the figures referenced but also applies to HTW from January 2020 until the COVID-19 public health emergency ends.

in state fiscal year 2021 for the implementation of postpartum services related to SB 750.

The services package for postpartum women enrolled in HTW, which became available on September 1, 2020, is referred to as HTW Plus.

HTW Plus services focus on treating major health conditions recognized as contributing to maternal morbidity and mortality in Texas:

- Postpartum depression and other mental health conditions
  - Services include individual, family and group psychotherapy services, and peer specialist services.
- Cardiovascular and coronary conditions
  - Services include imaging studies, blood pressure monitoring, and anticoagulant, antiplatelet, and antihypertensive medications.
- Substance use disorders, including drug, alcohol, and tobacco use
  - Services include screening, brief intervention, and referral for treatment (SBIRT); outpatient substance use counseling; smoking cessation services; medication-assisted treatment (MAT); and peer specialist services.

As required by SB 750, HHSC will seek an amendment to the 1115 waiver to receive federal funding to provide these enhanced services under the HTW program. HHSC intends to initiate the required public notice period on October 1, 2020, and submit the waiver amendment on December 1, 2020, with a requested CMS approval date of April 1, 2021. With CMS approval of the HTW Plus amendment to the HTW 1115 waiver, HTW Plus services will receive federal matching funds.

State and Federal Budgetary Impacts to HTW

COVID-19 is significantly impacting state and federal healthcare systems and the economy. To ensure maximum flexibility and avoid disruption in healthcare during the public health emergency, HHSC made changes to HTW, including:

- Allowing telemedicine and telehealth as service modalities to promote access to care while maintaining physical distance.
  - COVID-19 telemedicine and telehealth flexibilities for HTW align with Medicaid policies for these services.
- Adding COVID-19 testing as a benefit.
  - Currently, COVID-19 testing services are being paid with general revenue, but HHSC has submitted a disaster waiver amendment seeking retroactive

approval to receive federal funding for COVID-19 testing services under the HTW 1115 waiver.

- Extending HTW program eligibility for recipients.
  - Eligibility extensions are required for states to receive enhanced federal Medicaid match during the COVID-19 public health emergency. States must not terminate eligibility for the duration of the public health emergency unless the client is deceased, moves out of state, or voluntarily terminates coverage.
  - HTW recipients who have renewals due during the pandemic will get a notice on the next steps to take to maintain their coverage after the pandemic ends.

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Transition Plan Milestones

2021 Texas Legislative Session

DY 11 (Oct. 2021 – Sept. 2022)

December 2020

- Identify and submit to CMS any proposals for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas in DY 11 of current Waiver period
- Conduct a preliminary analysis of DY 7-8 DSRIP quality data and related core activities to outline lessons learned on health system performance measurement and improvement

March 2021

- Update the Texas Medicaid quality strategy and VBP Roadmap to address program goals and sustain key DSRIP initiatives
- Complete an assessment of which social factors are correlated with Texas Medicaid health outcomes

June 2021

- Assess Texas' current financial incentives for Medicaid MCOs and providers to enter into meaningful quality-based alternative payment models
- Identify options for the Regional Healthcare Partnership structure post-DSRIP
- Assess the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps

September 2021

- Identify and submit to CMS any additional proposals for new programs, including potential new Medicaid benefits, to sustain key DSRIP initiative areas that would start when the current waiver expires

Ongoing, Active Stakeholder Engagement

To Whom It May Concern:

The Texas Health and Human Services Commission (HHSC) appreciates the opportunity to provide comments on the proposed rule regarding Medicaid Program; Medicaid Fiscal Accountability Regulation, as requested in the *Federal Register* Vol. 84, No 222, issued on November 18, 2019 [File Code CMS–2393-P].

HHSC's comments follow.

General Comment

HHSC appreciates the desire on the part of the Centers for Medicare and Medicaid Services (CMS) to increase accountability related to public funds. The State of Texas strongly believes that the use and derivation of Medicaid funds should be widely understood so that taxpayers and Medicaid clients have the opportunity to examine how funds are spent in their name. However, HHSC believes portions of the proposed rules threaten to introduce unnecessary uncertainty and, in certain instances, exceed CMS's statutory authority.

HHSC supports CMS's efforts to have information about supplemental payments disseminated broadly. HHSC hopes that CMS will continue to work with stakeholders to find optimal ways to move forward with greater accountability in these vital programs.

HHSC's comments on specific provisions follow.

42 CFR § 430.42 Disallowance of claims for FFP

Comment

The proposed amendments to 42 CFR § 430.42 "alter the means of communication with regard to the disallowance reconsideration process from one based on registered or certified mail to one based on electronic mail or another electronic system as specified by the Secretary." See 84 Fed. Reg. 63737.

The State supports the use of electronic communication in the disallowance reconsideration process but asks that CMS amend § 430.42(a)(2)(C) to provide that State submissions are considered made on the date they are *sent*, rather than the date of receipt. The State does not have control over the time of receipt. This change would also align with § 430.42(c)(4)(i) and (c)(6), which provide that the Administrator's notification is considered made on the date it is sent by the Administrator.

The State also asks that CMS reexamine § 430.42(c)(3). The new sentence added to paragraph (3) addresses when "submissions are considered made" instead of when *notifications* are considered made. Given that in this paragraph CMS is sending a request to the State, the next sentence should relate to the date on which the State is notified of that request. "Submissions," on the other hand, seems to refer to what the State provides in response to the request, which is not addressed until the following paragraph (§ 430.42(c)(4)). The State suggests revising § 430.42(c)(3) to provide that notifications are considered made on the date they are *sent* by the Administrator and revising § 430.42(c)(4) to provide that *submissions* are considered made on the date they are sent via email or electronic system specified by the Administrator.

42 CFR § 433.51 State share of financial participation

Comment

HHSC requests that CMS reconsider its proposed revision of 42 CFR § 433.51, which HHSC believes is inconsistent with statute.

Section 1903(w)(6) of the Social Security Act says that "the *Secretary* may not restrict States' use of funds where such funds are derived from State or local taxes" (italics added) unless funds transferred from units of government are impermissible donations or taxes. The statute does not limit "public funds" to tax-generated and appropriated funds. Rather, that section of the Act restricts CMS's ability to limit states' use of funds derived from certain sources. It does not address public funds derived from other revenue sources, or imply that other revenue sources are not permitted.

HHSC believes that the same legislation that enacted section 1903(w)(6) of the Act is contrary to this proposed revision. Section 5(b) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 Public Law 102-234 (not codified) limits CMS's ability to change the treatment of "public funds as a source of State share of financial participation under title XIX" as reflected in the then-current regulations, now contained in 42 CFR § 433.51. The current regulation and its predecessors have directly authorized the use of any "public funds" (not limited to tax-generated funds), including those transferred or certified by "public agencies," as the non-federal share of Medicaid expenditures. HHSC believes that the Act does not permit CMS to limit the non-federal share of Medicaid payments beyond its specification of "public funds."

CMS intends the proposed replacement of "public funds" to clear up "confusion among states" with respect to the permissible sources of the non-federal share. 84 Fed. Reg. 63737. But the states are not confused. Congress was clear when it was considering the 1991 legislation that:

> *Current transfers from county or other local teaching hospitals continue to be permissible* if not derived from sources of revenue prohibited under this Act. (House Conference Report, emphasis in the original.)

As CMS itself explained in 1992, in connection with the interim final rule to implement Public Law 102-234:

> Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a States' share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations. 57 Fed. Reg. 55119.

CMS reiterated this understanding in 2007, when it published the ''Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership'' final rule. 72 Fed. Reg. 29748.[1] CMS noted "a perceived CMS position that the provisions of the regulation require that the sources of all IGTs must be state or local taxes." 72 Fed. Reg. 29766. To dispel this perception, CMS quoted section 1903(w)(6)(A) of the Act and said this statutory language "allows" (as opposed to requires) funding derived from State or local taxes to be used for purposes of financing the non-Federal share of Medicaid payments. *See id*. CMS went on to acknowledge that units of government that are not health care providers may collect revenue from a variety of sources. CMS included a non-exhaustive list of such sources and noted that any would be "acceptable sources of financing the non-Federal share of Medicaid payments, as long as the general fund does not derive any of its revenue from

[1] This final rule was rescinded in 2010. 75 Fed. Reg. 73972.

impermissible sources (such as 'recycled' Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations)." *Id*.

CMS then addressed governmentally-operated health care providers specifically:

> The governmentally-operated health care provider's account may include patient care revenues from other third-party payers and other revenues similar to those listed above. Such revenues would also be acceptable sources of financing the non-Federal share of Medicaid payments, as long as the governmentally-operated health care provider's operating account does not derive any of its revenue from impermissible sources (such as, ''recycled'' Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations). *Id*.

CMS concluded by saying providers are not required to demonstrate that funds transferred are, in fact, tax revenues; a governmentally-operated health care provider is always able to access tax revenue. *Id*.

Nothing has changed in the statute since the enactment of the 1991 legislation or the implementing regulations to warrant limiting permissible state or local funds that may be considered as the state share to the sources now specified in § 433.51. To the extent the proposed amendment is similar to the 2007 final rule that was later rescinded, the proposal is against the expressed will of Congress. As CMS recounts in this proposed rulemaking, "[a]fter a series of Congressional moratoria against its implementation, Congress stated its sense that it should not be implemented." 84 Fed. Reg. 63737.

If CMS were to impose such a change, there would be serious consequences on the continued ability of many public providers to participate in Medicaid programs that benefit Texas's most vulnerable residents. Some public providers may use patient care revenues as a source of the non-federal share of Medicaid payments. Restricting the source of the non-federal share in the way now proposed leaves public providers with a choice of serving vulnerable populations or raising taxes. HHSC recommends that CMS withdraw the proposed amendments to 42 CFR §433.51 and reaffirm that as long as there is sufficient public revenue for a unit of government to transfer funds for purposes of a Medicaid payment, such a transfer of funds is permitted under the Act.

HHSC also requests that CMS confirm that the non-federal share of certified public expenditures (CPEs) need not be derived from taxes. In discussing the phrase ''transferred from or certified by''

in section 1903(w)(6)(A) of the Act, CMS says the phrase refers to both the intergovernmental transfers (IGTs) and CPEs, respectively. Further, CMS states that the statute "clearly indicates that those funding mechanisms must be derived from state or local taxes (or funds appropriated to state university teaching hospitals)." 84 Fed. Reg. 63736. CMS attempts to make this understanding plain in the revision to § 433.51(b)(2), the subparagraph that refers to IGTs, by adding "derived from State or local taxes (or funds appropriated to State university teaching hospitals)," to the provision. CMS has not added that same language in § 433.51(b)(3), the subparagraph that refers to CPEs; that provision is silent as to the source of CPEs.

HHSC believes it is unreasonable to tie a certified public expenditure to taxes in this context. A CPE is simply a statement from a governmental entity that an expenditure was made. That expenditure, being made by a governmental entity, is by definition public. HHSC requests that CMS confirm that § 433.51(b)(3) does not require that CPEs be derived from taxes.

In summary, HHSC believes the proposed amendments to 42 CFR § 433.51 are inconsistent with statute, legislative intent, and longstanding federal practice. HHSC recommends that CMS withdraw this proposed amendment and reaffirm that "public funds" is the appropriate description of what may constitute the non-federal share of Medicaid payments.

42 CFR § 433.52 General definitions

Comment

HHSC is concerned that the proposed amendments to this section introduce ambiguity and uncertainty. The relationship between the proposed amendments to 42 CFR §§ 433.54 and 433.68 and the proposed definition of "net effect" in § 433.52 is unclear. Beyond being subjective, the "totality of the circumstances" and "net effect" tests appear to be duplicative. The proposed amendments to §§ 433.54 and 433.68 provide, "Such a guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the State (or other unit of government) and the provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or a related entity will receive a return of all or a portion of the donation." However, the proposed definition of "net effect" in 433.52 includes this language: "The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities…". To the extent CMS decides to retain such language, the State requests clarification regarding the interaction of these two provisions.

The definition of "net effect" includes language indicating that "reciprocal actions" will be considered. To the extent that CMS intends to consider actions among private parties in which neither the state nor local government has played a part, CMS lacks the statutory authority to do so. Please see comments related to § 433.68 for further explanation.

42 CFR § 433.54 Bona fide donations

Comment

HHSC is concerned that the proposed amendment replaces an objective test (for the existence of a hold harmless arrangement through a direct or indirect guarantee) with one that is subjective. The proposal would amend 42 CFR § 433.54(c)(3) to specify that such a guarantee will be found when "the net effect of an arrangement… results in a reasonable expectation that the provider, provider class, or related entities will receive a return of all or a portion of the donation either directly or indirectly." 84 Fed. Reg. 63739. This language comes from CMS's commentary to the February 2008 final rule titled "Medicaid Program; Health Care-Related Taxes," which introduced the "reasonable expectations" standard, and Departmental Appeals Board (DAB) Opinion No. 2886, Texas Health and Human Services Commission (2018), which introduced the "net effect" standard. If CMS adopts the proposed language, HHSC is concerned that the required analysis will be too subjective and variable to provide certainty as to what constitutes a direct or indirect guarantee. HHSC believes that criteria used to determine when there is an impermissible provider-related donation should be standardized and result in consistent outcomes.

As CMS has proposed amending § 433.54(c)(3), it appears that the new test for finding a hold harmless practice under this prong relates both to direct and indirect guarantees. Unlike the proposed amendment of § 433.68(f)(3) which says "[a] direct guarantee will be found to exist," the proposed amendment of § 433.54(c)(3) says "[s]uch a guarantee will be found to exist." However, it is not clear this is CMS's intention. The portion of the preamble that discusses this change says it applies to direct guarantees. *See* 84 Fed. Reg. 63739. Please clarify if the new language applies to both direct and indirect guarantees.

HHSC believes that the "net effect" standard is not a clarification of existing policy, but rather appears to consider the actions of unrelated third parties. *See* 84 Fed. Reg. 63739. CMS previously explained in its February 2008 final rule that "the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy." 73 Fed. Reg. 9694. Under the

proposal, however, CMS might find a direct guarantee based on the wholly private actions of unrelated third parties that are only incidentally related to any state statute, regulation, or policy.

The relationship between the proposed amendments to § 433.54 and the proposed definition of "net effect" in § 433.52 is unclear. The proposed amendments to § 433.54 provide, "Such a guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the State (or other unit of government) and the provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or a related entity will receive a return of all or a portion of the donation." However, the proposed definition of "net effect" in 433.52 includes this language: "The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities…" To the extent CMS decides to retain such language, the State requests that it clarify how these two provisions interact.

42 CFR § 433.55 Health care-related taxes defined

Comment

HHSC requests that CMS provide examples of what circumstances it would consider in applying the "totality of the circumstances" provision. Such a provision exists throughout the proposal, and it is not clear what may constitute such circumstances. HHSC is concerned that the ambiguity of such a test threatens to introduce uncertainty and will change over time depending on who is applying it. As with several of the provisions in this proposal, HHSC fears the text is so broad and nebulous that it may be costly, if not impossible, to monitor on an ongoing basis, and would make it difficult for states to engage in long-term planning.

42 CFR § 433.56 Classes of health care services and providers defined

Comment

HHSC supports CMS's proposal to add "health insurer" as a class of health care service as part of 42 CFR § 433.56. However, HHSC recommends that the term be defined not to include life or accident insurance policies. HHSC does not believe CMS intends to include such insurance policies under the "health insurer" class, but would be grateful for clarification.

42 CFR § 433.68 Permissible health care-related taxes

Comment

CMS proposes two substantial amendments to 42 CFR § 433.68. Proposed amendments to § 433.68(e) create a new "undue burden" standard in the context of health care-related tax waivers. Proposed amendments to § 433.68(f)(3) create a new "net effect" standard for determining if a hold harmless practice exists within the context of a health care-related tax. HHSC believes both amendments are improper. CMS's proposed amendments to 42 CFR § 433.68(f)(3) would add language to one of the three hold harmless tests used for determining the permissibility of a health care-related tax. The tests as they currently read are taken from statute verbatim.

HHSC believes that these proposed amendments are 1) contrary to statute; 2) not merely a clarification; and 3) so subjective that they cannot be implemented.

CMS's Proposal is Inconsistent with the Social Security Act

First, the proposed amendment to 42 CFR § 433.68(f)(3) is not consistent with section 1903(w) of the Social Security Act or its enabling legislation, the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234). In the preamble describing this rule, CMS states that it will find a hold harmless where taxpayers of a health care-related tax redistribute payments among themselves. However, unlike provider-related donations, Congress established specific "hold harmless" tests for provider-related taxes, rather than simply granting the Secretary the authority to do so.

Therefore, CMS is constrained by those sections of Social Security Act. Specifically, CMS is constrained by section 1903(w)(4)(C) of the Act, which provides that there is a hold harmless provision with respect to a broad-based health care related tax if "[t]he *State or other unit of government imposing the tax* provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax" (emphasis added). Congress specified that the hold harmless standard in § 433.68(f)(3) is tied to government, rather than private, conduct. Consequently, the proposed "net effect" standard, which CMS suggests can result in the denial of federal financial participation (FFP) based on the actions of the private taxpayer, is not supported by 1903(w)(4)(C). As CMS itself notes, Public Law 102-234 was intended to prohibit FFP "for health care-related taxes where *the state* has implemented a hold harmless provision." 73 Fed. Reg. 9690 (emphasis added).

CMS states that proposed § 433.68(f)(3) "aims to thwart efforts by states to skirt hold harmless provisions by paying supplemental payments to private entities, who then pass these funds on to other private entities that have lost gross revenue due to a health care-related tax." 84 Fed. Reg. 63742. However, despite the claim that state efforts or behavior is the problem, CMS states that it is targeting agreements between private parties. CMS appears to arrive at this result by attributing private decisions among private actors to the State and penalizing the State if the private actors' decisions are impermissible according to CMS. This proposed policy seems to assume that States must be involved with such agreements. However, CMS has offered no evidence (anecdotal or otherwise) that the States are part of any agreements between private parties that pay health care-related taxes.

CMS lacks statutory authority to hold the states responsible for the actions of private entities. The statutory language is clear that CMS's authority extends only as far as an arrangement that involves "the State or other unit of government imposing the tax provid[ing]…for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." *See* § 1903(w)(4)(C). CMS simply does not have the statutory authority to require states to police arrangements between private parties.

However, even if the Social Security Act authorized CMS to implement such a regulation, HHSC believes that the proposed amendment violates established principles of federalism, rooted in the Tenth Amendment to the Constitution and "the belief that issues that are not national in scope or significance are most appropriately addressed by the level of government closest to the people," by requiring states to monitor and regulate relationships between third parties. Executive Order 13132 on Federalism (August 4, 1999). Moreover, neither Congress nor the Executive branch have power to regulate private parties through the states. Where, as here, state governments identify uncertainties regarding the constitutional or statutory authority of the national government, the national government "should be deferential to the States when taking action that affects the policymaking discretion of the States and should act only with the greatest caution." *Id.*

While the States must assure that payments are consistent with efficiency, economy, and quality of care as required in section 1902(a)(30)(A) of the Social Security Act, the states are not required to regulate private arrangements between third parties. If the proposed amendment becomes final, HHSC does not know how it will legally discover, let alone restrict, any private arrangements CMS wants to eliminate.

In light of these uncertainties and the proposed policy's federalism implications, HHSC requests that CMS reconsider the legality and prudence of this part of the proposal.

The "Net Effect" Test is not a Clarification of Existing Policy

Second, CMS says that the "net effect" standard is a clarification of existing policy and would not impose any new obligations or restrictions on the States. 84 Fed. Reg. 63742. HHSC is concerned that this characterization is inaccurate. CMS previously explained in its February 2008 final rule that "the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy." 73 Fed. Reg. 9694. Under the proposal, however, CMS can find a direct guarantee based on the actions of third parties, not through the provision for payment by state statute, regulation, or policy.

Further, the claim that the standard represents existing policy is inconsistent with a 2003 HHS Inspector General (IG) report. In 2003, the HHS IG issued a report relating to the Missouri Disproportionate Share Hospital (DSH) program, of which the non-federal share was funded through a health care-related tax. *Review of Medicaid Disproportionate Share Funds Flow in the State of Missouri* (A-07-02-02097) (April 8, 2003). The report found that after the state had made DSH payments to individual hospitals in accordance with federal regulations and the State plan, the hospitals pooled the payments pursuant to private agreements, and a private association distributed the funds according to pooling formulas established by the private association to mitigate the effect of the health care-related tax. *Id.* The redistribution resulted in some hospitals receiving payments in excess of their DSH limits. *Id.* However, the IG determined that the redistribution agreements were voluntary between the hospital providers. Therefore, it could not recommend a disallowance because the federal government did not have the authority to reach such arrangements. *Id.*

In 2008, five years after the IG report was issued, CMS amended the health care-related tax provisions. 73 Fed. Reg. 9685-01. In response to comments on the proposed changes, CMS stated that it was "not aware of any state tax programs that would have been permissible under the Secretary's prior interpretation of the rules but are no longer permissible under the new rules." 73 Fed. Reg. 9690. Accordingly, Missouri hospitals' private agreements would not have been affected by the 2008 amendments. Now, however, CMS appears to believe that the new position announced in November 2019 is and always was the position of CMS. When it comes to the consistent application of the "net effects" standard, it is not possible to reconcile CMS's response to comments in 2008 and the position taken in MFAR.

The New Tests in 42 CFR §433.68 are Subjective, Leaving States in an Impossible Position

Third, HHSC is concerned that both proposed amendments to 42 CFR § 433.68(e) and (f)(3) are subjective and leave states entirely at the mercy of potentially shifting interpretations. If CMS adopts the proposed "undue burden," "net effects," "reasonable expectations," and "totality of the circumstances" language, any analysis of a health care-related tax will be subjective and variable, and HHSC believes there may be almost no certainty with regard to what will be deemed permissible. States must have certainty of, and protection under, the law in order to appropriately and efficiently operate any public program. The criteria used to determine when there is an impermissible health care-related tax should be standardized and result in consistent outcomes.

HHSC is concerned that the "undue burden" test proposed for § 433.68(e) changes what was once a quantitative analysis for health care-related tax waivers and adds an element that may lead to inequitable treatment across states. As discussed previously, the "net effects" test proposed for 42 CFR § 433.68(f)(3) is subjective and will also lead to inequitable treatment across states. HHSC recommends removing the proposed amendments to § 433.68.

In addition, as CMS has proposed amending § 433.68(f)(3), it appears that the new test for finding a hold harmless practice under this prong relates only to direct guarantees. Unlike the proposed amendment of § 433.54(c)(3) which says "[s]uch a guarantee will be found to exist," the proposed amendment of § 433.68(f)(3) says "[a] direct guarantee will be found to exist." However, it is not clear to HHSC whether this is CMS's intention. The portion of the preamble that discusses this change says it applies to both direct and indirect guarantees. *See* 84 Fed. Reg. 63742. HHSC requests that CMS clarify if, to the extent the amendments are adopted, the new language applies to both direct and indirect guarantees.

42 CFR § 433.72 Waiver provisions applicable to health care-related taxes

Comment

Although HHSC does not operate any health care-related taxes waivers, HHSC is concerned that a three-year renewal period, as proposed in 42 CFR § 433.72, is unnecessary. Such a change could be administratively burdensome and would be without justification. Such formal review and renewal of tax waivers is unnecessary, as the State already has ongoing responsibility to comply with all waivers granted by CMS. If facts have changed such that the previous approval of a tax waiver would be in doubt, a state would already be in discussions with CMS. Creation of tax programs is

highly sensitive and the specter of constant renegotiation provides no security for states or providers that must make such tax payments. HHSC recommends that CMS withdraw the proposed requirement for re-approval of health care-related tax waivers.

42 CFR § 433.316 When discovery of overpayment occurs and its significance

Comment

HHSC appreciates CMS's attempt to clarify when discovery of an overpayment occurs. However, even after the state submits the DSH independent certified audit report, changes can still occur as a result of litigation or other circumstances beyond the control of the state Medicaid agency. For example, HHSC has experienced litigation affecting the outcome of the audit. In 2013, HHSC was sued by a children's hospital regarding the appropriate calculation of the hospital specific limit. Likewise, CMS was sued by multiple hospitals regarding the same subject. Depending on the outcome of these lawsuits, HHSC might have been in the position of having to recoup payments from providers that would not otherwise be subject to recoupments once the audit report was updated. HHSC recommends that CMS make it clear that discovery of an overpayment will not be triggered if circumstances outside the control of the state Medicaid agency makes recoupments impossible.

42 CFR § 447.201 State plan requirements

Comment

HHSC has concerns that limiting variation in fee-for-service payment by eligibility category, as proposed in 42 CFR § 447.201, will have serious unanticipated consequences. All Medicaid programs must ensure that access is adequate for its members. Sometimes, a state must adopt higher rates to ensure provision of certain services to some categories of patients. For example, the rate necessary to assure adequate access for a service might be lower for an adult than it would for a child. The same could be true for an individual with intellectual or developmental disabilities. Medicaid programs often provide more complex and costly services to these individuals. However, having the same rate regardless of that important population distinction would necessitate higher rates than a state, or even the federal government, would typically find appropriate. Thus, there is a risk that in attempting to ensure efficiency, economy, and quality of care under the Social Security Act, the proposed amendment could have the opposite impact. The result of this proposed rule would be an unnecessary increase in federal and state spending.

To the extent CMS is concerned about states choosing higher rates solely on the basis on relative FMAPs, HHSC agrees that such a practice should be limited. However, states should be able to determine an appropriate rate for particular populations given the needs of those populations.

42 CFR § 447.206 Payments funded by certified public expenditures made to providers that are units of government

Comment

HHSC supports CMS's effort to make it clear that payments funded through CPEs must be limited to actual, incurred costs of providing covered services. But, section (b)(4) of the proposed new 42 CFR § 447.206 would require that the certifying entity of the CPE must receive and retain the full amount of FFP. This appears to be inconsistent with Social Security Act section 1902(a)(32) and 42 CFR § 447.10, which permit a Medicaid provider to assign a Medicaid payment to a governmental agency or entity. HHSC recommends removing Section (b)(4) of the proposed rule.

42 CFR § 447.207 Retention of payments

Comment

Proposed 42 CFR § 447.207 attempts to require that a Medicaid provider retain its Medicaid payments. In determining whether a Medicaid provider is retaining such payments, the proposal says it will consider "associated transactions." Such transactions "may include, but are not necessarily limited to, the payment of an administrative fee to the State for processing provider payments…." Texas suggests clarifying that "associated transactions" would not include an administrative fee to the state for the purpose of enhancing the state's oversight of the Medicaid program.

The preamble states, "Payment arrangements that comply with an exception in section 1902(a)(32) of the Act and the implementing regulation in § 447.10 would not be deemed out of compliance with this proposed provision." 84 Fed. Reg. 63746. The preamble also states, "We have noted circumstances in some states where participation in a Medicaid supplemental payment under the state plan is conditioned upon the state receiving a portion of that payment back…." *Id*. CMS seems to imply that conditioning participation in such a manner is impermissible. CMS's position is wholly inconsistent with the Social Security Act. Section 1902(a)(32)(B) of the Act permits assignment to a government agency. The widely accepted definition of "assignment" is "the transfer of rights or property." *See* Black's Law Dictionary (11th ed. 2019). This broad definition does not

prohibit the assignee from conditioning a thing of value on the assignment (e.g., conditioning a Medicaid supplemental payment on the assignment), and section 1902(a)(32)(B) contains no such requirement. CMS should clarify that a state may condition participation in a Medicaid supplemental payment program on an assignment under 1902(a)(32)(B).

HHSC is attempting to expand its monitoring capabilities for supplemental payments and the sources of the non-federal share. However, to do that, HHSC must pay for that increased administration. By hindering states' abilities to cover that added administrative burden, CMS sets states up for failure. CMS should allow for administrative fees scaled to benefits accrued to providers. A flat fee across a broad class of providers has a deleterious effect on smaller, often struggling, providers. For example, if the state were to charge an application fee of $100 on all hospitals that wish to participate in an upper payment limit (UPL) supplemental payment program, that $100 is far more important to a hospital that would receive a $1,000 UPL payment than a hospital that would receive a $10,000 UPL payment. Limiting Medicaid participation on the part of smaller or struggling providers limits access for patients and encourages provider concentration.

42 CFR § 447.252 State plan requirements

Comment

HHSC has two concerns regarding the proposed 42 CFR § 447.252, which creates new requirements related to supplemental payments under the state plan. First, HHSC believes the three-year re-approval of state plan-based supplemental payments is unnecessary and ill-advised. There is simply not enough certainty under the proposed rule for states to effectively operate their Medicaid programs while seeking such frequent re-approvals. Additionally, it is not clear why such programs must be re-approved at all. Currently, the federal government has tools to determine if Medicaid programs, including state plan-authorized supplemental payment programs, comply with the law. CMS operates financial management reviews and HHS IG conducts audits.

Second, the proposed monitoring plan is administratively burdensome. States typically create a program in line with the original approvals from CMS. If any changes to those programs are considered, it is part of the normal course of business for a state to compare such changes to the previous CMS approval and, if CMS approval is necessary to implement such changes, request that approval. Accordingly, a plan for ongoing monitoring is unnecessary and burdensome.

Lastly, HHSC is concerned that CMS does not have adequate administrative capacity to review and approve these new SPAs, especially if it intends to thoroughly review monitoring plans and the results of those plans. With this new responsibility, in addition to the proposed tax waiver renewals and the normal course of business, HHSC fears it will be a challenge for CMS to timely review these submissions. These administrative capacity issues could indirectly impact review of state submissions that are not otherwise related to these new rules. HHSC requests that CMS remove the required re-approvals of state plan-based supplemental payments and monitoring plans.

42 CFR § 447.272 Inpatient services: Application of upper payment limits

Comment

HHSC agrees with CMS's attempts to limit wasteful spending but is concerned that the description of UPLs contained in 42 CFR § 447.272 will have a detrimental impact on a key eligibility group in Medicaid: children. In large part, Medicare and Medicaid cover different populations. One of the largest populations covered by Medicaid is children. In Texas, roughly 62% of the more than 4,000,000 Medicaid clients are under the age of 14. Medicare is a program largely developed for those over the age of 65. The needs, costs, and expectations of the two programs are not aligned. In determining UPLs, HHSC requests that CMS consider the significant amount of care provided to children in Medicaid.

42 CFR § 447.284 Basis and purpose

Comment

HHSC requests clarification of the limitations of new Subpart D as described in this section. The text of the proposal seems to set out requirements for supplemental payments made under the state plan. However, the preamble's use of the term "supplemental payment" seems as though it can apply to both payments made through Section 1115 Waiver authority and even some managed care payments, in addition to the state plan. *See* 84 Fed. Reg. 63726. HHSC requests that CMS clarify that the requirements described in new Subpart D apply only to supplemental payments authorized through the state plan.

42 CFR § 447.286 Definitions

Comment

HHSC is concerned that the proposed definitions in proposed 42 CFR § 447.286 are vague and unduly burdensome. First, CMS seeks to define "supplemental payment" and distinguish it from "base payment." Unfortunately, it is not clear to HHSC how some payments would be categorized. CMS states in the definition that such payments "cannot be attributed to a particular provider claim for specific services provided to an individual beneficiary and are often made to the provider in a lump sum." HHSC fears that this proposed change unnecessarily introduces subjectivity and uncertainty.

For example, CMS states in the preamble that it is possible for certain managed care payments to be considered supplemental payments. HHSC agrees that pass-through payments described in 42 CFR § 438.6(d) could be considered supplemental payments. However, directed payment programs under § 438.6(c) are put in question by the proposal. All such payments are to be paid out based on Medicaid utilization, so they can be tied to services provided to an individual beneficiary. In addition, it is possible for directed payments to be made in a lump sum. HHSC requests that CMS confirm that pass-through payments described in § 438.6(d) are the only form of managed care payment that would be considered a "supplemental payment" for purposes of the proposed rule.

Second, CMS defines state and non-state government provider. HHSC is concerned that this change, too, introduces unnecessary subjectivity and uncertainty. With the exception of reporting the results of UPL demonstrations, states are traditionally relied upon to determine ownership of various health care entities. States should continue to be the entities making such determinations. In addition, CMS extends to this section the inconsistencies related to the non-federal share that HHSC has pointed out in 42 CFR § 433.51 on state share of financial participation. The proposed changes will only increase the administrative burden on states and leave states unsure as to how categorize many providers.

42 CFR § 447.288 Reporting requirements for upper payment limit demonstrations and supplemental payments

Comment

Regarding the proposed reporting requirements for supplemental payments in 42 CFR § 447.288, as previously stated, HHSC fully supports efforts to increase transparency of these payments. HHSC is

taking steps itself to make information about such payments more broadly accessible to the public on an ongoing basis.

However, HHSC has two suggestions regarding the proposal. First, HHSC does not believe reporting should be necessary more than annually. It is not clear to HHSC what benefit the public derives through quarterly reporting. Second, HHSC suggests removing the requirement that a physical address be included in the report. Given the fluid nature of provider identification numbers in relation to physical address, such information is not possible to report.

Additionally, HHSC does not act as an intermediary between providers and the Medicaid managed care organizations regarding their specific payment arrangements, except in certain circumstances as permitted under 42 CFR § 438.6(c). As such, HHSC does not believe that payments to providers made by a Medicaid managed care organization should be subject to the upper payment limit demonstration, as the provider payments made by the Medicaid managed care organization are presumed to be, as already required under §1902(a)(30)(A) of the Act, "consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers."

42 CFR § 447.290 Failure to report required information

Comment

While HHSC supports generally the proposed reporting requirements for supplemental payments, it believes that the proposed penalty for failure to report is not consistent with the Social Security Act or existing CMS regulations.

CMS proposes in 42 CFR § 447.290(b) to reduce future grant awards through deferral if a state fails to timely, completely, and accurately report information required under 42 CFR § 447.288. Under proposed § 447.290(b), a grant award can be reduced by the amount of FFP that CMS estimates to be attributable to payments made to the provider(s) as to which the state has not reported properly. CMS gives itself authority to defer FFP even if a state submits the required report but the report fails to comply with applicable requirements. According to CMS, "[o]therwise allowable FFP for expenditures deferred in accordance with this proposed section would be released when we determine that the state has complied with all reporting requirements under proposed § 447.288." *See* 84 Fed. Reg. at 63758.

CMS says the proposed deferral under § 447.290(b) will be in accordance with 42 CFR § 430.40, but § 447.290(b) as proposed is inconsistent with § 430.40. First, § 430.40 authorizes deferred

payments only when CMS questions the allowability of the claimed expenditure and needs additional information to resolve the question; the regulation does not allow deferral as a result of noncompliance with CMS regulations (e.g., noncompliance with § 477.288). Additionally, and contrary to § 447.290(b) as proposed, a deferral pursuant to § 430.40 is not indefinite. Generally, funds may be deferred for 90 days, at which point CMS must either release the funds or take a disallowance (and provide appeal rights to the State). *See* 42 CFR § 430.40(c)(5)-(6).

Finally, CMS should not finalize § 447.290(b) as proposed because it already has the authority to impose a remedy for noncompliance with CMS regulations. The proper remedy for noncompliance with CMS regulations is section 1904 of the Social Security Act, which provides that CMS may only withhold funds "after reasonable notice and hearing to the state agency." Given the foregoing, the penalty for failing to comply with the proposed reporting requirements should be consistent with the notice and hearing requirements of section 1904.

42 CFR § 447.297 Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992

Comment

HHSC requests that CMS adopt no proposed changes to 42 CFR § 447.297 in order to avoid inadvertently hindering states' ability to operate their programs. First, for planning purposes, it is extremely helpful for a state to know by a date certain what the DSH allotment will be for that state. For example, HHSC takes the DSH allotments into account when determining the appropriate amount of funds for other supplemental and directed payment programs. If DSH allotment dates were to slip, it is difficult for states to adjust payment timelines, which have become quite complex. It is rare for HHSC to have an open space in its supplemental and directed payment calendar due to limited administrative capacity.

Second, HHSC objects to removing the requirement that the DSH allotments be posted in the Federal Register. Nothing prevents CMS from posting the allotments in whatever electronic format it believes would be widely accessible. However, from the standpoint of continued reliability, the Federal Register is a known, regularly published source of information that can only be updated through later publicly released issues, and accordingly provides a reliable, permanent public record. Therefore, HHSC would recommend continuing to require posting of the DSH allotment in the Federal Register in addition to any other online source CMS finds appropriate.

42 CFR § 447.299 Reporting requirements

Comment

Auditors have noted that state Medicaid agencies, including HHSC, do not have access to out-of-state payment information. This has the potential to hinder the determination of the financial impact of audit findings. Will CMS require Medicaid agencies to provide out-of-state payment information to auditors of other states? If so, how will such a requirement be implemented to allow for other states to access each other's Medicaid Management Information System (MMIS)?

In addition, HHSC has no general concern with the proposed timelines for collection of overpayments and issuance of redistributions. However, there are sometimes issues outside the control of the state. For instance, as discussed in our comment on 42 CFR § 433.316, HHSC has experience with litigation that resulted in the state not collecting overpayments and issuing redistributions as that litigation directly impacted such actions. HHSC requests that CMS make allowance in rule for issues outside of state government control, such as litigation.

42 CFR § 447.302 State plan requirements

Comment

HHSC has the same concerns with proposed 42 CFR § 447.302, which creates new requirements related to supplemental payments under the state plan, as it does with 42 CFR § 447.252. First, HHSC believes the three-year re-approval of state plan-based supplemental payments is unnecessary and ill-advised. There is simply not enough certainty under the proposed rule for states to effectively operate their Medicaid programs while seeking such frequent re-approvals. Additionally, it is not clear why such programs must be re-approved at all. Currently, the federal government has tools to determine if Medicaid programs, including state plan-authorized supplemental payment programs, comply with the law. CMS operates financial management reviews and HHS IG conducts audits.

Second, the proposed monitoring plan is administratively burdensome. States typically create a program in line with the original approvals from CMS. If any changes to those programs are considered, it is part of the normal course of business for a state to compare such changes to the previous CMS approval and, if CMS approval is necessary to implement such changes, request that approval. Accordingly, a plan for ongoing monitoring is unnecessary and burdensome.

Lastly, HHSC is concerned that CMS does not have adequate administrative capacity to review and approve these new SPAs, especially if it intends to thoroughly review monitoring plans and the results of those plans. With this new responsibility, in addition to the proposed tax waiver renewals and the normal course of business, HHSC fears it will be a challenge for CMS to timely review these submissions. These administrative capacity issues could indirectly impact review of state submissions that are not otherwise related to these new rules. HHSC requests that CMS remove the required re-approvals of state plan-based supplemental payments and monitoring plans.

42 CFR § 447.321 Outpatient hospital services: Application of upper payment limits

Comment

HHSC shares the same concerns with proposed 42 CFR § 447.321 as it did with 42 CFR § 447.272. HHSC agrees with CMS's attempts to limit wasteful spending but is concerned that the description of UPLs contained in § 447.321 will have a detrimental impact on a key eligibility group in Medicaid: children. In large part, Medicare and Medicaid cover different populations. One of the largest populations covered by Medicaid is children. In Texas, roughly 62% of the more than 4,000,000 Medicaid clients are under the age of 14. Medicare is a program largely developed for those over the age of 65. The needs, costs, and expectations of the two programs are not aligned. In determining UPLs, HHSC requests that CMS consider the significant amount of care provided to children in Medicaid.

42 CFR § 447.406 Medicaid practitioner supplemental payment

Comment

Although HHSC does not currently operate any programs that would be impacted by the cap on Medicaid practitioner supplemental payments proposed by 42 CFR § 447.406, HHSC does not understand why a cap is necessary, particularly the one described in the proposed rule. In general, payments must currently be consistent with efficiency, economy, and quality of care. HHSC believes that further limits beyond those laid out in statute are unnecessary.

42 CFR § 455.301 Definitions

Comment

As noted above in comments on 42 CFR § 447.299, auditors have noted that state Medicaid agencies, including HHSC, do not have access to out-of-state payment information to determine the

financial impact of a finding related to such payments. The DSH audit rule preamble states that "(w)hen the State has the most central and current information through its MMIS (for example, data on Medicaid payments in State fee-for-service inpatient hospital, outpatient hospital and DSH payments) that system will be the best source of the information." HHSC requests that CMS clarify whether it will require Medicaid agencies to provide out-of-state payment information to auditors of other states. HHSC also requests clarification regarding how such a requirement may be implemented to allow for other states to access each other's MMIS.

42 CFR § 457.609 Process and calculation of State allotments for a fiscal year after FY 2008

Comment

While HHSC appreciates CMS's attempt to find user-friendly means of disseminating information, the CHIP allotments should officially be posted in the Federal Register. Nothing prevents CMS from posting the allotments in whatever electronic format it believes would be widely accessible. However, from the standpoint of continued reliability, the Federal Register is a known, regularly published source of information that can only be updated through later publicly released issues. As such, HHSC would recommend posting the CHIP allotment in the Federal Register in addition to any other online source CMS finds appropriate.