

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ASPECTS OF TEXAS' QUALITY INCENTIVE
PAYMENT PROGRAM RAISE QUESTIONS
ABOUT ITS ABILITY TO PROMOTE ECONOMY
AND EFFICIENCY IN THE MEDICAID
PROGRAM**

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Office of Inspector General

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Report in Brief

Date: December 2020

Report No. A-06-18-07001

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

In September 2017, Texas began making incentive payments to nursing facilities under its Quality Incentive Payment Program (QIPP). The purpose of QIPP is to encourage nursing facilities to improve the quality and innovation of their services. Improvement is based on several quality measures that are collected by the Centers for Medicare & Medicaid Services (CMS). Texas estimated that the total QIPP expenditures would be about \$2.6 billion for Federal fiscal year (FY) 2018 through FY 2022. The Social Security Act requires States to have methods and procedures to assure that Medicaid payments are consistent with efficiency, economy, and quality of care.

Our objective was to provide information about QIPP that CMS can use to determine whether it promotes economy and efficiency in the Medicaid program.

How OIG Did This Audit

We reviewed the flow of QIPP funds totaling \$193.7 million (\$110 million Federal share) during the first 6 months of the program (September 2017 through February 2018). Our audit included an analysis of bank and accounting records from a judgmental sample of 10 nursing facilities participating in QIPP. We also reviewed the CMS Five-Star Quality Ratings for nursing facilities that participated in QIPP to identify trends in the quality of nursing facility care.

Aspects of Texas' Quality Incentive Payment Program Raise Questions About Its Ability To Promote Economy and Efficiency in the Medicaid Program

What OIG Found

Certain aspects of QIPP raise questions about its ability to promote economy and efficiency in Medicaid. Specifically: (1) nursing facilities received less than half of the earned incentive payments; (2) nursing facilities participating in QIPP generally rated below average in overall quality; (3) nursing facilities that declined in performance continued to receive quality improvement incentive payments; and (4) two local government entities participating in QIPP funded \$1.3 million (\$737,944 Federal share) of the non-Federal share of QIPP payments through intergovernmental transfers (IGTs) financed by means of debt instruments.

QIPP provides some incentives for nursing facilities to improve the quality of resident care. However, the results of our audit suggest that further analysis of the program is warranted.

What OIG Recommends

We recommend that CMS: (1) work with Texas to determine whether the source of IGTs and the practice of using debt instruments to fund the non-Federal share of QIPP payments meets program objectives and promotes economy and efficiency in Medicaid; and (2) reevaluate Texas' QIPP to ensure that it operates in a manner that meets program objectives while promoting economy and efficiency in Medicaid.

Texas did not concur with our first recommendation and stated that there is no CMS regulation or policy and no legal basis or precedent for our position that IGTs were from an impermissible source. While we acknowledge that Federal rules do not clearly indicate whether loans meet the definition of a permissible source for an IGT, we continue to have concerns that debt instruments, particularly when secured to ensure sufficient IGT funds, may not meet program objectives. And given the impact that the use of debt instruments had on the timing of the nursing facilities receiving any of the earned incentive payments, we have concerns that the nursing facilities' ability to make improvements in quality could be impacted. Texas did concur with our second recommendation.

CMS concurred with our first recommendation, implied agreement with our second recommendation, and outlined actions it has taken and plans to take to address our findings and recommendations.

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

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INTRODUCTION

WHY WE DID THIS AUDIT

In September 2017, Texas began making incentive payments to nursing facilities under its Quality Incentive Payment Program (QIPP, the program). The purpose of QIPP is to encourage nursing facilities to improve the quality and innovation of their services. Improvement is based on several quality measures that are collected by the Centers for Medicare & Medicaid Services (CMS). The Texas Health and Human Services Commission (State agency) estimated that total QIPP expenditures would be about \$2.6 billion for Federal fiscal year (FY) 2018 through FY 2022—almost 40 percent more than the \$1.03 billion in total expenditures made under the previous two nursing facility supplemental payment programs that were in place in Texas from FY 2014 through FY 2017.¹

The Social Security Act (the Act) requires that States have methods and procedures to ensure Medicaid payments are consistent with efficiency, economy, and quality of care.² With the goal of evaluating whether QIPP promotes economy and efficiency in the Medicaid program, this audit takes a broad look at QIPP costs and resources, and whether the program operates in a way that best achieves its objective, which is to improve the quality of care provided in Texas nursing facilities.

OBJECTIVE

Our objective was to provide information about QIPP that CMS can use to determine whether it promotes economy and efficiency in the Medicaid program.

BACKGROUND

The Medicaid Program

The Act authorizes Federal grants to States for Medicaid programs to provide medical assistance to persons with limited income and resources. Although Medicaid programs are administered by the States, they are jointly financed by the Federal and State Governments. The Federal Government pays its share of medical assistance expenditures to States on a quarterly basis according to a formula described in sections 1903 and 1905(b) of the Act. The Federal share of medical assistance expenditures is called the Federal financial participation

¹ The prior two nursing facility supplemental payment programs in Texas were the nursing facility Upper Payment Limit (UPL) program, in place from October 2013 through February 2015, which paid \$235 million (\$137 million Federal share), and the Minimum Payment Amount Program (MPAP), in place from March 2015 through April 2017, which paid \$794 million (\$455 million Federal share) to participating Texas nursing facilities.

² The Act § 1902(a)(30)(A).

(FFP), and it is calculated using the State's Federal Medical Assistance Percentage (FMAP).³ States pay their shares of medical expenditures in accordance with section 1902(a)(2) of the Act.

States may implement delivery system and provider payment initiatives under Managed Care Organization (MCO) contracts by requiring that MCOs participate in a Medicaid-specific delivery system reform or performance improvement initiative.⁴

Texas Nursing Facility Ownership Arrangements

In Texas, nursing facilities can be privately owned (referred to in this report as private nursing facilities); State owned; or owned by a non-State-government entity (NSGE) such as a hospital authority, hospital district, health care district, city, or county. When an NSGE acquires a nursing facility, a change-of-ownership agreement (CHOW) is finalized, and the NSGE becomes the holder of the nursing facility's license and party to the nursing facility's Medicaid provider enrollment agreement with the State.⁵

In this report, we refer to nursing facilities that are acquired by NSGEs as non-State government-owned (NSGO) facilities. As discussed further below, prior Texas nursing facility programs limited participation to NSGO facilities. As a result, changes of ownership have become more common, and the percentage and number of Texas nursing facilities owned by NSGEs has increased significantly.

Texas Nursing Facility Payment Programs

QIPP is the most recent of three payment programs in Texas that have provided additional funding to nursing facilities. The first was the Upper Payment Limit (UPL) Program, which was replaced by the Minimum Payment Amount Program (MPAP). Texas discontinued MPAP after CMS found that the State share of supplemental payments was financed by non-bona fide, provider-related donations,⁶ and MPAP did not fulfill the requirements of a "Delivery System Reform or performance improvement initiative"⁷ as described in 42 CFR § 438.6.

³ FMAP is the percentage rate used to determine the Federal matching funds for Medicaid expenditures. The statutory minimum FMAP is 50 percent, and the maximum is 83 percent.

⁴ 42 CFR § 438.6(c)(1)(ii).

⁵ Based on our review, after the CHOW was finalized the NSGE entered into three separate agreements with the prior nursing facility owners for lease, management, and operations. If any of the legal agreements are terminated, ownership of the facility returns to the original owners.

⁶ A non-bona fide, provider-related donation occurs when a private entity provides a government entity with funds or other considerations and in turn receives additional Medicaid payments, typically in the form of supplemental payments.

⁷ This was reported to the audit team by a CMS Regional Office official.

Upper Payment Limit Program

The Texas nursing facility UPL Program began in October 2013 and ended in February 2015. Texas made supplemental Medicaid payments under the UPL Program to qualifying NSGO facilities. These payments were calculated to meet Federal UPL requirements.⁸ Under this program, a participating NSGE would contribute the non-Federal share of the supplemental payment through an intergovernmental transfer (IGT).⁹ During the almost 2 years that Texas operated the UPL Program, Texas made payments to 238 NSGO facilities that totaled \$234,892,281 (\$136,674,203 Federal share).

Minimum Payment Amount Program

After Texas began including nursing services under its Medicaid Managed Care Program, it replaced the UPL Program with MPAP. MPAP began in March 2015 and ended in April 2017. As with the UPL Program, MPAP limited participation to NSGO facilities. Under MPAP, MCOs made additional Medicaid payments to qualifying NSGO facilities. These payments were based on the State agency's UPL calculation. During the 2 years that Texas operated MPAP, Texas made payments to 279 participating NSGO facilities that totaled \$793,644,654 (\$454,838,143 Federal share).

Texas Quality Incentive Payment Program

QIPP succeeded MPAP in September 2017 and has been approved by CMS to run through September 2022. QIPP operates as part of the Texas Healthcare Transformation and Quality Improvement Program Waiver (the waiver),¹⁰ which provides health care services delivered through MCOs. QIPP is designed to improve quality and innovation in the provision of nursing facility services, and provides incentive payments to nursing facilities that meet performance requirements on specified quality measures. According to the State agency's request to CMS for QIPP approval, payments from MCOs to qualified nursing facilities would "be based on improvements on specific quality measures." The State agency also stated that nursing facilities "must make incremental improvements toward preset goals to qualify for payments." Unlike the payments that were made under the UPL Program and MPAP, QIPP payments are available to private nursing facilities as well as NSGO facilities. Once appropriately claimed by the State, Federal regulations do not dictate how QIPP payments must be used by NSGE, NSGO facilities, or privately owned facilities.

⁸ Federal regulations at 42 CFR § 447.272 allow States to claim Federal matching funds under Medicaid for up to what Medicare would pay for a similar service (i.e., the upper payment limit).

⁹ IGTs are transfers of funds from another government entity (e.g., a county, city, or another State agency) to a State Medicaid agency.

¹⁰ CMS approved the waiver under section 1115 of the Act. The latest waiver renewal is effective from Oct. 1, 2017, through Sept. 30, 2022.

QIPP payments are comprised of three components. Component One payments are available only to NSGO facilities and are calculated to equal 110 percent of the IGTs that NSGEs provide to the State agency as the State share of QIPP funding. Texas defines an IGT as a “transfer of public funds”¹¹ such as “taxes, assessments, levies, investments,” or “other public revenues.”¹² Component One payments are made to NSGEs each month that NSGO facilities submit a Quality Assurance Performance Improvement (QAPI) Validation Report to the State agency.¹³ These payments are retained in full by the NSGEs. Component Two and Component Three payments are available to all QIPP-participating nursing facilities that meet individual performance requirements (described below), and are based on the amount of QIPP funding available after Component One payments are made. In addition to Component One, Component Two, and Component Three payments, all QIPP nursing facilities are eligible for “lapse funds.” Lapse funds are funds that are not distributed because one or more nursing facilities failed to meet QAPI reporting requirements or quality metrics. Lapse funds are redistributed to all nursing facilities based on each nursing facility’s proportion of the combined total QIPP-earned Component One, Component Two, and Component Three funds. MCOs retain a small percentage of the payments and lapse funds, and pay the balance to NSGEs and private nursing facilities.

The State agency determines nursing facilities’ eligibility for incentive payments from 4 of 24 quality measures available under CMS’s Five-Star Quality Rating System. Under the rating system, each nursing facility is assigned one overall rating and a separate rating for each of three areas: health inspections, quality measures, and staffing.¹⁴

- The health inspections rating is based on the number, scope, and severity of deficiencies identified during annual State inspection surveys that occurred before November 28, 2017, as well as substantiated findings from complaint investigations that occurred during the 24 months before November 28, 2017.
- The quality measures rating is based on the individual nursing facility’s performance in 16 of the 24 quality measures, 9 of which are long-stay quality measures, and 7 of which are short-stay quality measures. The four measures used for year 1 of QIPP were long-stay quality measures: (1) the percentage of residents with pressure ulcers; (2) the percentage of residents who received antipsychotic medication; (3) the percentage of residents experiencing one or more falls with major injury; and (4) the percentage of residents who were physically restrained.

¹¹ Texas Administrative Code (TAC) § 353.1301(b)(4).

¹² TAC § 353.1301(b)(10).

¹³ TAC § 353.1303(b)(10). QAPI is a monthly report submitted by a nursing facility that is eligible for and enrolled in QIPP to an MCO that demonstrates that the nursing facility has convened a meeting to review its CMS-compliant plan for maintaining and improving the facility’s safety and quality.

¹⁴ CMS, *Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users’ Guide*, May 2018.

- The staffing rating is based on two measures: total nursing staffing hours per resident, per day; and registered nurse hours per resident, per day. Other staff services at a nursing facility, such as clerical or housekeeping services, are not included in the staffing rating calculation.

During our audit period, NSGEs that we audited retained at least half of the Component Two and Component Three payments received from MCOs. NSGEs then paid the remaining amounts to their NSGO facilities. MCOs make QIPP payments to private nursing facilities directly to the facility owners. Appendix B provides an example of QIPP payment methodology.

In its first year, 428 NSGO facilities and 85 private nursing facilities participated in QIPP, and budgeted expenditures for QIPP totaled \$400 million. In the second year, 460 NSGO facilities and 95 private nursing facilities were eligible to participate in QIPP, and the budgeted expenditures totaled \$446 million. On February 5, 2019, the State agency announced that it would allocate \$600 million to QIPP for year 3 (State FY 2020). In the third year, 459 NSGO facilities and 339 private nursing facilities were eligible to participate in QIPP.

Nursing Facility Performance Requirements for Component Two and Component Three Payments

Quarterly Component Two and Component Three payments are triggered by a nursing facility's achievement of certain quality metrics. These quality metrics derive from the Five-Star Quality Rating System.¹⁵ At the time of our audit, the rating system included 24 measures for short- and long-stay nursing home residents, 16 of which factored into a facility's quality of resident care rating.¹⁶ During our audit period, Component Two and Component Three payments were based on four of those measures: (1) the percentage of high-risk long-stay residents with pressure ulcers; (2) the percentage of long-stay residents who received an antipsychotic medication; (3) the percentage of residents who experienced one or more falls that resulted in a major injury; and (4) the percentage of residents who were physically restrained.¹⁷

A participating nursing facility's eligibility for Component Two and Component Three payments is measured by comparing the facility's performance on each metric to either a facility-specific "baseline" or a national "benchmark." Quality metric baselines are determined by each nursing facility's average performance on the metric for the Federal quarter that ends before the first day of the QIPP eligibility period and the three, prior Federal quarters. Benchmarks are determined by the national average for the metric for the Federal quarter that ends before the

¹⁵ CMS created the rating system to help consumers compare nursing homes more easily. The ratings include data for both Medicare and Medicaid. Nursing homes with five stars are considered to have a quality level much above average, while the quality of nursing homes with one star is considered much below average. For each nursing home, there is one overall rating but separate ratings relating to recent health inspection results, nursing facility staffing, and physical and clinical quality measures.

¹⁶ CMS, *Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide*, May 2018.

¹⁷ TAC § 353.1303(h)(2)(i).

first day of the QIPP eligibility period. To be eligible for Component Two or Component Three payments, a nursing facility must either show improvement over the baseline or perform better than the benchmark for a given metric.¹⁸ See Appendix C for a complete list of the Five-Star Quality Rating System's 16 quality measures.

HOW WE CONDUCTED THIS AUDIT

We reviewed the flow of QIPP funds among the Federal Government, State agency, MCOs, NSGEs, and nursing facilities for the first 6 months of the program (September 2017 through February 2018). During that period, QIPP expenditures totaled \$193,682,943 (\$109,953,973 Federal share). Our audit included an analysis of bank and accounting records from a judgmental sample of 10 nursing facilities participating in the QIPP. We selected 1 NSGO facility each from a judgmental sample of 8 NSGEs that owned 96 individual NSGO facilities participating in the QIPP:

- 3 NSGEs that received a QIPP payment of at least \$1 million,
- 3 NSGEs that received a QIPP payment of between \$200,000 and \$999,999, and
- 2 NSGEs that received a QIPP payment of less than \$200,000.

We also selected two privately owned nursing facilities: One had received the largest QIPP payment, and the other had received the smallest QIPP payment. We reviewed the CMS Five-Star Quality Ratings for nursing facilities that participated in QIPP during its first year (September 2017 through August 2018) to identify any trends in the quality of nursing facility care during that time. Lastly, we held discussions with State agency, MCO, NSGE, NSGO facility, and privately owned facility officials to gain an understanding of QIPP requirements and operations.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

We are providing the following information about QIPP that CMS can use to determine whether QIPP promotes economy and efficiency in Medicaid. Specifically:

¹⁸ TAC § 353.1303(i)(2).

- Nursing facilities received less than half of the earned incentive payments. Of the \$110 million in Federal contributions for QIPP during our audit period, private nursing facilities received \$16 million, and NSGO facilities received approximately \$36 million,¹⁹ which totaled less than half of the Federal outlays. NSGEs that own the NSGO facilities retained \$44 million of the payments, and the MCOs retained \$14 million to cover various fees and taxes. Further analysis could determine whether the QIPP could better promote quality improvement and efficiency if participating nursing facilities received a greater share of those incentive payments.
- During our audit period, only 4 of a possible 24 quality measures were used to determine incentive payment eligibility. Further analysis could determine whether QIPP could better promote quality improvement and an efficient allocation of incentive payments if eligibility for those payments were based on a broader set of quality measures that may more accurately reflect nursing facility quality.
- Nursing facilities that declined in performance, as reflected by at least one quality metric, continued to receive quality improvement incentive payments. Nursing facilities qualified for incentive payments if they performed better than the national average benchmark on at least one of the four performance metrics. Some facilities that qualified for incentive payments by performing better than the national average did not show facility-specific, incremental quality improvement. These facilities decreased in certain quality metrics specific to their facility, which may indicate that the facility was performing more poorly. Further analysis could determine whether a more efficient use of Federal funds could be achieved if incentive payment eligibility requirements and associated quality performance metrics were better aligned with the stated objective of the program—to make incremental improvements in quality.

In addition, we found that the State share of two QIPP payments totaling \$1,300,000 (\$737,994 Federal share) was funded by IGTs that came from debt instruments. One NSGE IGT was funded from the proceeds of a bank promissory note (\$800,000), while another NSGE drew on part of a bank line of credit (\$500,000).

NURSING FACILITIES RECEIVED LESS THAN HALF OF EARNED INCENTIVE PAYMENTS

During the first 6 months of the program (September 2017 through February 2018), QIPP expenditures totaled \$193,682,943 (\$109,953,973 Federal share). The following is a more detailed breakdown of the \$193,682,943 in QIPP expenditures:

¹⁹ We did not identify the exact amount of funds retained by the NSGEs. Instead, we approximated this total by assuming that NSGEs retained 50 percent of the \$72,829,294 (for a total of \$36,414,647) in Component Two and Component Three payments that passed through the MCOs. Because of the nonstatistical nature of our sample, we cannot calculate the precision of this approximation. However, we maintain that the approximation is reasonable, given that the 50-percent rate was identified in 93 of 96 NSGOs in our sample.

- \$52,108,360 (26.9 percent) was paid as Component Two and Component Three payments directly to QIPP nursing facilities, of which:
 - \$36,414,647²⁰ (18.8 percent) went to 428 NSGO nursing facilities and
 - \$15,693,659 (8.1 percent) went to 85 privately owned nursing facilities;
- \$128,178,982 (66.2 percent) was paid as Component One, Component Two, and Component Three payments and retained by NSGEs including:²¹
 - \$91,764,335 in Component One payments and
 - \$36,414,647 in Component Two and Component Three payments; and
- \$13,395,655 (7 percent) was retained by MCOs.

Given the amount of QIPP funds retained by NSGEs, we attempted to review how the funds were spent. We found that NSGEs retain their share of the QIPP payments in a general fund or general revenue account. This same account is used for collecting Medicare, private insurance, tax revenue, and other forms of payments for hospitals operated by NSGEs. As a result, we were unable to determine how the QIPP funds were spent. When asked how NSGEs in our sample spent the QIPP funds retained, NSGE officials reported spending their portion of the QIPP payments on hospital expenses; operating a hospital is the major business purpose of an NSGE.

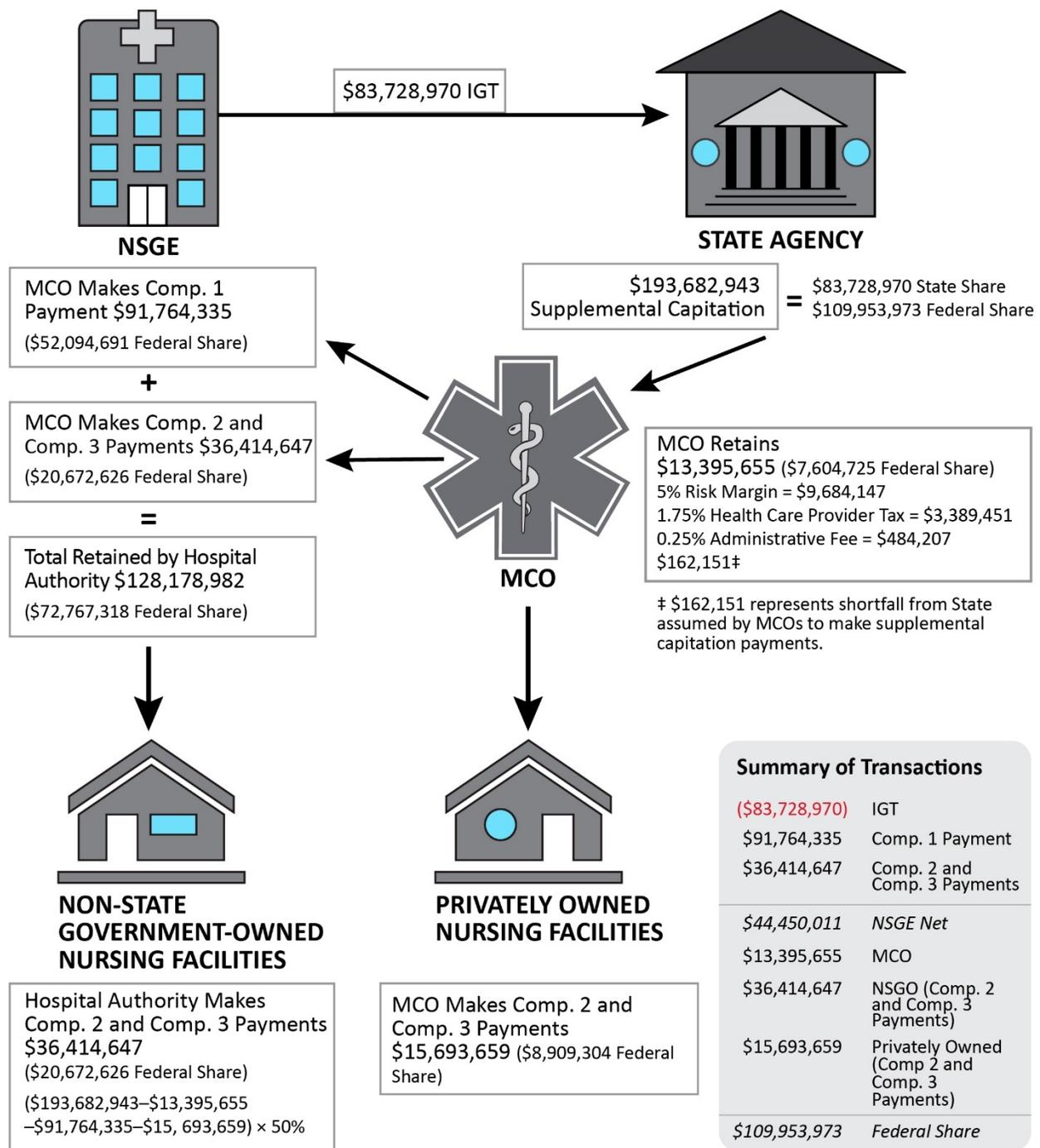
We also found that NSGO facilities and privately owned facilities deposited QIPP funds in accounts with ordinary nursing facility revenue. As a result, we were unable to determine whether the portion of the Component Two and Component Three payments paid to NSGO and privately owned facilities was used toward efforts to improve quality of care for Medicaid beneficiaries.

Finally, MCOs retained a portion of the QIPP funds before distributing the QIPP payments. MCOs retained 5 percent of the QIPP funds as a risk margin to cover possible future obligations, 1.75 percent to pay the State agency's health care-related tax on MCO revenue, and 0.25 percent as an administrative fee for processing QIPP payments. In the State agency's QIPP application approved by CMS, there was no mention that MCOs would retain a portion of the QIPP funds; however, it is set out in the contracts between the State and MCOs as part of the managed care payments. The figure on the following page illustrates the QIPP flow of funds for our audit period.

²⁰ This total and the corresponding Component Two and Component Three payments retained by NSGEs are approximations. See footnote 15 for details.

²¹ Of this amount, \$83,728,916 represented the non-Federal share of QIPP funds contributed by NSGEs.

Figure: The Texas Quality Incentive Payment Program Flow of Funds for Our Audit Period*



* The distribution of funds depicted in this figure assumes that the flow of funding across all participating nursing facilities was the same as the flow of funding related to the 10 nursing facilities that we sampled. Because the flow of funding at the sampled nursing facilities was consistent, we believe our assumption is fair.

Further analysis could determine whether a payment structure that ensures nursing facilities receive a greater share of incentive payments may better promote economy and efficiency in Medicaid.

QUALITY OF NURSING FACILITIES PARTICIPATING IN THE QUALITY INCENTIVE PAYMENT PROGRAM GENERALLY RATED BELOW AVERAGE

Quality of Nursing Facilities in Year 1

As shown below in Table 1, the quality of QIPP-participating nursing facilities as measured by CMS’s Five-Star Quality Rating System during year 1 of QIPP was generally below average. Specifically, 59.6 percent of participating nursing facilities had an overall star rating of “below average” (two stars) or “much below average” (one star). Among participating nursing facilities, 51.7 percent had a health inspections star rating of below average or much below average, 25 percent had a resident care star rating of below average or much below average, and almost 90 percent had a staffing star rating of below average or much below average.

Table 1: Summary of CMS Five-Star Quality Ratings for QIPP Nursing Facilities—Year 1

Annual Average Rating	Overall Rating	Health Inspection Rating	Quality of Resident Care Rating	Staffing Rating
Average Score	2.6	2.7	3.6	1.8
Number of Nursing Facilities				
5	22	25	94	2
Between 4 and 4.9	80	105	140	10
Between 3 and 3.9	105	118	151	47
Between 2 and 2.9	136	145	86	139
Between 1 and 1.9	170	120	42	315
Rating Below 3.0	59.6%	51.7%	25%	88.5%

Changes in Quality Incentive Payment Program Metrics

Beginning in September 2019, Texas amended its QIPP metrics by removing the metrics addressing residents who experienced one or more falls that resulted in a major injury and residents who were physically restrained.²² These two metrics were replaced by one metric that targets residents whose ability to move independently worsened, three metrics addressing infection control, and three metrics that address staffing. The first two measure the length of skilled nursing coverage. The third requires that the nursing facility have a staffing recruitment

²² Texas Health and Human Services, *Final Quality Metrics for Quality Incentive Payment Program (QIPP) FY2020 for Nursing Facilities*, <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2020.pdf>. Accessed on June 3, 2019.

and retention program that includes plans for monitoring program outcomes. The three metrics addressing infection control included one that measures the percentage of residents with a urinary tract infection, one that measures the percentage of residents with up-to-date coverage of pneumococcal vaccines, and one that requires development of an infection control program at the facility that includes antimicrobial stewardship.²³

Texas is also collecting additional data on staffing and infection control to track involuntary terminations, recruitment, and retention of staff; the number of residents with multidrug-resistant organisms; the number of vaccines administered to residents and employees; the number of diagnoses of *Clostridium difficile* among residents; and the number of residents on antibiotic medications.²⁴

We are encouraged that the State implemented additional quality measures for QIPP. However, we are uncertain whether these additional measures will improve how QIPP is capturing improvements in quality at participating nursing facilities. Further analysis by CMS will be needed to assess the impact of these new quality measures.

NURSING FACILITIES THAT DECLINED IN PERFORMANCE CONTINUED TO RECEIVE QUALITY IMPROVEMENT INCENTIVE PAYMENTS

In November 2015, the State agency published a concept paper that described QIPP as “designed to incentivize nursing facilities to improve quality and innovation in the provision of nursing facility services, including payment incentives to establish culture change, small house models, staffing enhancements, and outcome measures to improve the quality of care for nursing facility residents.”²⁵ According to the State agency’s request to CMS for QIPP approval, payments from MCOs to qualified nursing facilities would be “based on improvements on specific quality indicators.” The State agency also stated in that document that the nursing facilities “must make incremental improvements towards pre-set goals to qualify for payments.”

Nursing facilities can qualify for Component Two and Component Three payments in one of two ways: by improving specific quality indicators from the individual baseline, or by exceeding a benchmark score representing the national average rating of all nursing facilities on a given performance measure. Specifically, to qualify for a Component Two payment a facility had to

²³ Antimicrobial stewardship promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infection by multidrug-resistant organisms.

²⁴ Texas Health and Human Services, *Final Quality Metrics for Quality Incentive Payment Program (QIPP) FY2020 for Nursing Facilities*, <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2020.pdf>. Accessed on June 3, 2019, pp. 8, 10-12.

²⁵ Texas Health and Human Services Commission, *Concept Paper: Texas Quality Incentive Payment Program* (Nov. 20, 2015).

improve by 1.7 percent and 3.4 percent above an individual baseline²⁶ for the first and second quarter of QIPP, respectively; to qualify for a Component Three payment, the percentages of improvement had to be 5 percent and 10 percent, respectively. Component Two and Component Three payments were also available by exceeding the benchmark²⁷ for at least one of the four measures used in QIPP.

During our audit period, some nursing facilities qualified for incentive payments by performing better than the national average but did not show facility-specific incremental quality improvements. Although these facilities exceeded the national benchmark and qualified for Component Two and Component Three payments, certain quality metrics specific to each facility declined, which may indicate poor performance.²⁸ Specifically, we found that during the first and second quarters of QIPP:

- A total of 109 nursing facilities²⁹ (68 facilities in the first quarter and 81 facilities in the second quarter) declined in performance relative to the previous quarter but qualified for Component Two and Component Three payments in the falls metric by performing better than the national benchmark for that metric. These nursing facilities received \$3,565,379 in Component Two and Component Three payments.
- A total of 93 nursing facilities³⁰ (61 facilities in the first quarter and 53 facilities in the second quarter) declined in performance relative to the previous quarter but qualified for Component Two and Component Three payments in the pressure ulcers metric by performing better than the national benchmark for that metric. These nursing facilities received \$2,319,429 in Component Two and Component Three payments.
- A total of 101 nursing facilities³¹ (76 facilities in the first quarter and 64 facilities in the second quarter) declined in performance relative to the previous quarter but qualified for Component Two and Component Three payments in the use of antipsychotic medication metric by performing better than the national benchmark for that metric.

²⁶ A baseline is a nursing facility-specific starting measure used as a comparison against nursing facility performance throughout the eligibility period to determine progress in the QIPP Quality Measures (TAC § 353.1303(b)(1)).

²⁷ A benchmark is a CMS national average before the start of the eligibility period by which a nursing facility's progress with the QIPP Quality Measures is determined (TAC § 353.1303(b)(2)).

²⁸ A nursing facility that exceeds the benchmark for a metric qualifies for a payment from both Component Two and Component Three for that metric. A nursing facility that exceeds the benchmark may decline in performance and still qualify for payments from both Component Two and Component Three as long as the nursing facility continues to exceed the benchmark for the metric (TAC § 353.1303(i)(2)(C)).

²⁹ The 109 nursing facilities represent the unduplicated count of nursing facilities.

³⁰ The 93 nursing facilities represent the unduplicated count of nursing facilities.

³¹ The 101 nursing facilities represent the unduplicated count of nursing facilities.

These nursing facilities received \$3,155,995 in Component Two and Component Three payments.

In aggregate, we found that during the first two quarters of QIPP, 238 (46.4 percent) of 513 nursing facilities declined in performance in an individual quality metric but qualified for Component Two and Component Three payments for that metric—totaling \$9,040,803 (10.2 percent) of the \$88,522,953 in total Component Two and Component Three payments made for the audit period—because they still performed better than the national average.

The September 2019 change in QIPP metrics approved by CMS to address staffing, infection control, and other areas of resident care has been a positive step, but further analysis could determine whether QIPP could better promote quality improvement and an efficient allocation of incentive payments by basing eligibility for those payments on a broader set of measures that show a more complete picture of nursing facility quality. We are, however, encouraged that the changes being made to the metrics in the third year of QIPP are consistent with the intent of QIPP, which is to improve quality.

Further analysis could determine whether a more efficient use of Federal funds could be achieved if incentive payment eligibility requirements and associated quality performance metrics were better aligned with the stated objective of the program, which is to make incremental improvements in quality.

THE NON-FEDERAL SHARE OF TWO QUALITY INCENTIVE PAYMENT PROGRAM PAYMENTS WAS FUNDED BY INTERGOVERNMENTAL TRANSFERS THAT CAME FROM DEBT INSTRUMENTS

The Secretary of Health and Human Services may not restrict the States' use of funds derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of Medicaid expenditures.³² Public funds may be considered as the non-Federal share in claiming FFP if they are transferred from other public agencies to the State or local agency and are under that agency's administrative control.³³ Texas defines IGTs as a "transfer of public funds"³⁴ and public funds as "funds derived from taxes, assessments, levies, and investments," including "other public revenues within the sole and unrestricted control of a governmental entity."³⁵

We identified two NSGEs with IGTs that were used to fund the non-Federal share of QIPP payments totaling \$1,600,284, of which \$1,300,000 (\$737,944 Federal share) came from debt

³² The Act § 1903(w)(6)(A).

³³ 42 CFR § 433.51.

³⁴ TAC § 353.1301(b)(4).

³⁵ TAC § 353.1301(b)(10).

instruments.³⁶ These IGTs were funded in part from the proceeds of a bank promissory note (\$800,000) and part of a bank line of credit (\$500,000). The portion of these IGTs derived from loans may not meet the definition of public funds. According to an official at one of the NSGEs, the NSGE took out the promissory note to fund its IGT so that the NSGE's safety reserve of funding would not be depleted. In our review of bank records at the other NSGE, the NSGE did not have sufficient cash available to fully fund its IGT without drawing on a line of credit.

The availability of QIPP funds to a nursing facility depends in part on the size of the related NSGE's IGT. By using debt instruments to fund their IGTs, the two NSGEs were able to secure an amount of QIPP funds that was higher than they would have received if their IGTs had been less. However, the NSGEs used QIPP funds to first pay off their debt and did not provide the nursing facilities with any of the earned incentive payment until 5 and 7 months, respectively, after the NSGEs initially received the QIPP funds. Delays in nursing facilities receiving earned incentive payments could impact the nursing facilities' ability to make improvements in quality.

CONCLUSION

QIPP provides some incentive for nursing facilities to improve the quality of resident care. However, the results of our audit suggest that QIPP may not be meeting the goals of the waiver, and further analysis of the program could determine whether:

- a payment structure that ensures nursing facilities receive a greater share of incentive payments would promote the goals of QIPP and
- QIPP could better promote incremental improvements in quality if eligibility for the incentive payments were based on quality performance metrics that show a more accurate picture of nursing facility quality.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- work with Texas to determine whether the source of IGTs and the practice of using debt instruments to fund the non-Federal share of QIPP payments meets program objectives and promotes economy and efficiency in Medicaid, and
- reevaluate QIPP to ensure that it operates in a manner that meets program objectives while promoting economy and efficiency in Medicaid.

³⁶ Statement No. 88 of the Governmental Accounting Standards Board (GASB) defines debt as "a liability that arises from a contractual obligation that is expected to be settled using cash on demand or on fixed or determinable dates."

TEXAS HEALTH AND HUMAN SERVICES COMMISSION COMMENTS

In written comments on our draft report, the State agency primarily addressed the recommendations made to CMS in the report and commented only on the finding that nursing facilities received less than half of the earned incentive payments. However, the State agency did not address the validity of the finding. Instead, the State agency stated that no Federal regulations restrict the amount of funds that a nursing facility owner can or should retain, and that it is unaware of a reason that ownership of a nursing facility by an NSGE should be treated differently from other ownership arrangements.

The State agency did not concur with our first recommendation and requested that it be removed from the report. The State agency stated that there is no CMS regulation or policy, and no legal basis or precedent, for our position that IGTs were from an impermissible source. The State agency also stated that it had no notice of prohibition on accepting loan funds as IGTs, and further noted two instances (a prior OIG report and a Departmental Appeals Board (DAB) decision) of CMS or OIG identifying loan funds as the source of IGT, stating that in neither case were the loan funds the basis for an adverse finding. In addition, the State agency stated that it does not have any rules that prohibit loans as IGTs, and suggested the Texas Administrative Code supports that loans fall within the definition of public funds. The State agency stated that the Financial Accounting Standards Board (FASB) and GASB standards we referred to in correspondence with the State are not applicable, and that the State interprets “public revenue” under its State plan to include loan funds.

The State agency concurred with our second recommendation and outlined actions it has taken and plans to take to evaluate its QIPP and strengthen the program. For example, the State agency stated that it is transforming its health care delivery system to value-based care, increasingly linking provider payments to measures of quality. In addition, the State agency said that it continues to monitor and assess performance and make improvements to strengthen the program on an ongoing basis. To further advance value-based care and improve quality and innovation in the provision of nursing facility services, the State agency stated that it expanded QIPP quality metrics beginning in State FY 2020 (effective September 1, 2019) and that the enhanced incentive criteria, developed in collaboration with stakeholders, include staffing and other new metrics that require more effort by providers to attain.

The State agency’s comments are included as Appendix E with the exception of Exhibit 1, which we excluded because it contained sensitive information.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding the State agency’s comments on the finding that nursing facilities received less than half of earned incentive payments, we did not find that the payment structure was improper; rather, we noted that further analysis of the payment structure may be warranted.

Regarding our first recommendation, we acknowledge that Federal rules do not clearly indicate whether loans meet the definition of a permissible source for an IGT. However, we continue to

have concerns that debt instruments, particularly when secured to ensure sufficient IGT funds, may not meet program objectives. In regard to the two instances the State agency noted in which loan funds as the source of IGT were not the basis for an adverse finding, we would point out that the prior OIG report that the State agency referenced generally identified the State's use of IGTs from counties' loan funds to obtain FFP as an example of a financing structure designed solely to maximize Federal Medicaid reimbursements. In addition, the DAB decision that the State agency cited did not specifically identify any loan funds that were used as IGTs. Regarding the FASB and GASB standards, we would clarify that in the absence of specific regulatory language defining public revenue, we referred to generally applicable accounting terminology. We recognize that the State interprets "public revenue" under its State plan to include loan funds.

We did not remove the recommendation but revised it to request that CMS work with the State to determine whether the source of IGTs and the practice of using debt instruments to fund the non-Federal share of QIPP payments ensures that QIPP meets its objectives and promotes economy and efficiency in Medicaid. In addition, we revised the heading and added language to our finding to clarify why one NSGE secured a debt instrument, that the second NSGE did not have sufficient revenue to fund its IGT without drawing on an existing debt instrument, and the impact that the use of debt instruments had on the timing of the nursing facilities receiving any of the earned incentive payment. We have concerns that the delays that the nursing facilities experienced in receiving earned incentive payments could impact the nursing facilities' ability to make improvements in quality.

We commend the State agency for its action plan to improve QIPP and its willingness to continue to identify areas for improving the program.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our first recommendation, implied agreement with our second recommendation, and stated it is committed to ensuring that QIPP meets program objectives and promotes economy and efficiency in the Medicaid program. Specifically, CMS stated that it has been communicating with and providing technical assistance to the State to ensure that future QIPP submissions, in the years subsequent to the period under OIG's review, meet program objectives while promoting economy and efficiency in Medicaid. In addition, CMS stated that it reevaluates most State-directed payment arrangements on an annual basis and will reevaluate the payment arrangement with the State's submission of the State FY 2022 preprint to ensure alignment with Federal regulatory requirements for State-directed payments, as well as the recommendations and requirements CMS outlined in its approval of the State FY 2021 payment agreement. As part of this evaluation, CMS stated it will also consider whether the allocation of certain QIPP funds continues to raise concerns about the link of payments to utilization, delivery of services, or quality under the contract. CMS's comments are included in their entirety as Appendix F.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

During the first two quarters of QIPP, covering the period of September 2017 through April 2018, the State agency made \$193,682,943 (Federal share \$109,953,973) in supplemental capitation payments for nursing facility services. These payments were made to 62 hospital NSGEs as well as 85 private nursing facilities. The 62 hospital NSGEs represented ownership of 428 nursing facilities. At the time of our review, there were 513 nursing facilities in QIPP.

We did not review the overall internal control structure of Texas' Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining the flow of QIPP funds and the effect on the nursing facilities' quality of care. We did not extend our review to any other supplemental Medicaid payment programs in Texas.

We performed our fieldwork at the State agency's office in Austin, Texas; MCO offices; NSGOs; and the nursing facilities in our sample.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal statutes, regulations, and guidance pertaining to incentive payments;
- reviewed the Texas Administrative Code pertaining to the UPL, MPAP, and QIPP supplemental payment programs;
- held a discussion with CMS and State agency officials to gain an understanding of QIPP program requirements and operations;
- collected QIPP payment data from State agency officials to review aggregate program payment activity;
- reviewed the flow of funds from the State agency to MCOs, and then to NSGEs and private nursing facilities, for the first 6 months of the QIPP;
- selected a judgmental sample of 10 nursing facilities to review (8 NSGO and 2 privately owned nursing facilities), and selected 1 NSGO facility each from a judgmental sample of 8 NSGEs including:
 - 3 NSGEs that each received a QIPP payment of at least \$1 million,
 - 3 NSGEs that each received a QIPP payment of between \$200,000 and \$999,999,

- 2 NSGEs that each received a QIPP payment of less than \$200,000, and
- 2 privately owned nursing facilities that received the largest and the smallest QIPP payment, respectively, for the period;
- reviewed judgmentally selected nursing facilities' banking and accounting records and QAPI documents;
- interviewed staff at 8 hospital NSGEs, 8 related nursing facilities, and 2 private nursing facilities to determine the flow of funds for QIPP payments;
- applied the distribution of QIPP funds we identified in our audit of the 10 nursing facilities in our sample to approximate the aggregate payments made to NSGO facilities and private nursing facilities;
- held discussions with MCO, NSGE, and NSGO facility officials to gain an understanding of the QIPP payment process;
- reviewed and summarized CMS's Five-Star Quality Rating System for all 513 QIPP nursing facilities for year 1 of the QIPP (September 2017 through August 2018); and
- met with CMS officials to discuss our findings and recommendations.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: TEXAS QUALITY INCENTIVE PAYMENT PROGRAM METHODOLOGY

QIPP payments consist of three components:

- Component One payments are only available to NSGEs and are 110 percent of the IGT amount. To qualify, an eligible facility owned by an NSGE is required to conduct a monthly QAPI³⁷ meeting that must be documented in a QAPI Validation Report (Appendix D) and sent to the State agency. The State agency then instructs MCOs to make the Component One payment to the NSGE.
- Component Two and Component Three payments are available to all participating facilities. Payments are based on four quality measures for long-stay residents that are used in the CMS Five-Star Quality Rating System. These measures are:
 - percentage of residents experiencing one or more falls with a major injury;
 - percentage of high-risk residents with pressure ulcers;
 - percentage of residents who were physically restrained; and
 - percentage of long-stay residents who received antipsychotic medications.

Nursing facilities qualify for Component Two and Component Three payments if their quarterly measures meet or exceed the required quarterly improvement goals. QIPP performance standards are shown in Tables 5 and 6 in Appendix C.

After the subtraction of the Component One payments, Component Two and Component Three payments are equal to 35 percent and 65 percent of the remaining QIPP funds, respectively. Lapse funds (remaining balance of undistributed QIPP funds) are then redistributed to all QIPP nursing facilities based on each nursing facility's proportion of total earned QIPP funds. This redistribution is based on each nursing facility's proportion of total earned QIPP funds from Components One, Two, and Three combined.³⁸ The State sends the Quality Measure scorecards to the MCOs, which have 20 days to pay NSGEs and private nursing facilities.

Tables 2, 3, and 4 on the following pages illustrate the calculation of Component Two and Component Three payments, as well as the distribution of lapse funds. The total pool of available funds in these examples is \$15,000.

³⁷ QAPI requirements are found in 42 CFR § 438.330.

³⁸ TAC § 353.1303(g)(4).

Table 2: Sample Calculation of Component Two QIPP Payments

Quarter Measure—Percentage of Residents Who Were Physically Retrained								
National Average (Benchmark) = 0.53%								
Total QIPP funds available = \$15,000								
Component One Funds = \$1,250 per facility (\$5,000/4 facilities)								
<i>Component Two Funds Available = \$3,500 ((\$15,000–\$5,000) x 35%)*</i>								
Nursing Facility	Base-line	Base-line Target	Actual Result	Bench-mark Target	Met or Failed Baseline Target	Met or Failed Benchmark Target	Undistributed QIPP Funds (Lapse Funds)[†]	Component Two Payment
A	0.10%	0.098%	0.00%	0.53%	Met	Met	\$0	\$875
B	5.03%	4.944%	2.22%	0.53%	Met	Failed	0	875
C	0.25%	0.246%	0.40%	0.53%	Failed	Met	0	875
D	1.00%	0.983%	1.50%	0.53%	Failed	Failed	875	0
Total Component Two Payments								\$2,625

* In this example, a total of \$3,500 in Component Two funds is available to be distributed evenly to nursing facilities that met their performance goals.

[†] Lapse funds are QIPP funds that were undistributed because the nursing facility failed to meet its quality metric.

Table 3: Sample Calculation of Component Three QIPP Payments

Quarter Measure—Percentage of Residents Who Were Physically Retrained								
National Average (Benchmark) = 0.53%								
Total QIPP funds available = \$15,000								
Component One Funds = \$1,250 per facility (\$5,000/4 facilities)								
<i>Component Three Funds Available = \$6,500 ((\$15,000–\$5,000) x 65%)*</i>								
Nursing Facility	Base-line	Base-line Target	Actual Result	Bench-mark Target	Met or Failed Baseline Target	Met or Failed Benchmark Target	Undistributed QIPP Funds (Lapse Funds)[†]	Component Three Payment
A	0.10%	0.095%	0.00%	0.53%	Met	Met	\$0	\$1,625
B	5.03%	4.779%	2.22%	0.53%	Met	Failed	0	1,625
C	0.25%	0.238%	0.40%	0.53%	Failed	Met	0	1,625
D	1.00%	0.950%	1.50%	0.53%	Failed	Failed	1,625	0
Total Component Three Payments								\$4,875

* In this example, a total of \$6,500 in Component Three funds is available to be distributed evenly to nursing facilities that met their performance goals.

[†] Lapse funds are QIPP funds that were undistributed because the nursing facility failed to meet its quality metric.

Table 4: End-of-Year QIPP Fund Distribution

Total QIPP funds available = \$15,000							
Nursing Facility	Component One Payment*	Component Two Payment	Component Three Payment	Components One, Two, and Three Payments	Share of Components One, Two, and Three Payments [†]	Lapse Fund Payments [‡]	Total QIPP Payment ^{**}
A	\$1,250	\$875	\$1,625	\$3,750	30%	\$750	\$4,500
B	1,250	875	1,625	3,750	30%	750	4,500
C	1,250	875	1,625	3,750	30%	750	4,500
D	1,250	0	0	1,250	10%	250	1,500
Total	\$5,000	\$2,625	\$4,875	\$12,500		\$2,500	\$15,000

* In this example, Component One funds of \$5,000 are distributed evenly to all nursing facilities.

[†] This was calculated by dividing the Component One, Component Two, and Component Three payments per facility by the total Component One, Component Two, and Component Three payments for all facilities.

[‡] Lapse funds are distributed to each nursing facility proportional to the total amount of Component One, Component Two, and Component Three payments earned.

** Total QIPP payments equal Component One, Component Two, and Component Three payments plus lapse fund payments.

APPENDIX C: CMS FIVE-STAR QUALITY RATING SYSTEM MEASURES³⁹ AND QUALITY INCENTIVE PAYMENT PROGRAM PERFORMANCE STANDARDS⁴⁰

CMS FIVE-STAR QUALITY RATING SYSTEM MEASURES

Measures for Long-Stay Residents

- Percentage of residents whose need for help with activities of daily living has increased
- Percentage of residents whose ability to move independently worsened
- Percentage of high-risk residents with pressure ulcers (sores)
- Percentage of residents who have or had a catheter inserted and left in the bladder
- Percentage of residents who were physically restrained
- Percentage of residents with a urinary tract infection
- Percentage of residents who self-report moderate to severe pain
- Percentage of residents experiencing one or more falls with major injury
- Percentage of residents who received an antipsychotic medication

Measures for Short-Stay Residents

- Percentage of residents whose physical function improves from admission to discharge
- Percentage of residents with pressure ulcers (sores) that are new or have worsened
- Percentage of residents who self-report moderate to severe pain
- Percentage of residents who have newly received an antipsychotic medication
- Percentage of residents who were re-hospitalized after a nursing home admission
- Percentage of residents who have had an outpatient emergency department visit
- Percentage of residents who were successfully discharged to the community

³⁹ CMS, *Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide*, May 2018.

⁴⁰ There are 24 Quality Measures. The 16 Quality Measures selected by CMS for its Quality of Resident Care rating were selected based on their validity and reliability to affect a measure of change in a nursing facility's statistical performance and importance.

PERFORMANCE STANDARDS FOR THE TEXAS QUALITY INCENTIVE PAYMENT PROGRAM

Table 5: QIPP National Average Benchmarks for Year 1*

Quality Measure (Long Stay)	Year 1
Percent of high-risk long-stay residents with pressure ulcers	5.67%
Percent of residents who were physically restrained	0.53%
Percent of residents experiencing one or more falls with a major injury	3.35%
Percent of long-stay residents who received an antipsychotic medication	16.06%

* <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-year-one-summary-report.pdf>.

Table 6: QIPP Quarterly Improvements Required To Earn Payments for Year 1*

Total Improvement Required From Baseline		
Quarter	For Component Two	For Component Three
1	1.7%	5%
2	3.4%	10%
3	5.1%	15%
4	7.0%	20%

* <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/provider-information/qipp-concept-paper.pdf>.

APPENDIX D: QUALITY ASSURANCE PERFORMANCE IMPROVEMENT VALIDATION REPORT



TEXAS
Health and Human
Services

Texas Health and Human Services Commission

Charles Smith
Executive Commissioner

Quality Assurance Performance Improvement (QAPI)

Validation Report

I _____ on behalf of _____ hereby attest that this facility conducted its monthly QAPI meeting on _____ at _____.

I understand that both holding the monthly meeting and correctly submitting this document are contingent upon receiving payments under Component 1 of the Quality Incentive Payment Program (QIPP), as set forth in the UMCM contract, and in compliance the rules set forth in 1 TAC Chapter 353, Subchapter O, §§353.1301 and 353.1303 concerning the Quality Incentive Payment Program (QIPP).

I further understand that this form will be considered submitted correctly:

- if received by HHSC by close of business on the first business day of the following month;
- the submission is completed through the following link: https://www.surveymonkey.com/r/QIPP_QAPI_Submission; and
- the uploaded file is named with the following information:
 - Facility Name
 - Month The Meeting Took Place
 - Example: Stoneybrook Manor September

If any information given to or investigation on behalf of HHSC determines that the attestation herein is false or misleading, I understand that this facility may be required to participate in an audit and/or pay back any funds related to Component 1 of QIPP (i.e., QAPI).

Signature of Responsible Party Listed Above

Date of Signature

P.O. Box 13247 • Austin, Texas 78711-3247 • 512-424-6500 • hhs.texas.gov

If you have any questions or concerns about monthly the QAPI Validation Report, please email MCS_QIPP_QAPI@hhsc.state.tx.us with a clearly titled Subject line.

APPENDIX E: TEXAS HEALTH AND HUMAN SERVICES COMMISSION COMMENTS



TEXAS
Health and Human
Services

Texas Health and Human Services Commission

Phil Wilson
Executive Commissioner

June 8, 2020

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Re: Number A-06-18-07001

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Aspects of Texas' Quality Incentive Payment Program Raise Questions About Its Ability to Promote Economy and Efficiency in The Medicaid Program" from the U.S. Department of Health and Human Services Office of Inspector General. The cover letter, dated April 6, 2020, requested that HHSC provide written comments, including a statement of concurrence or nonconcurrence with each recommendation and the reasons for our non-concurrence or the status of actions taken or planned in response to report recommendations for which we concur.

I appreciate the opportunity to respond. Please find the attached HHSC management response, which (a) includes comments related to the content of the findings and recommendations; (b) our reasons for any non-concurrence; and/or (c) detailed actions HHSC has completed or planned.

Should you need additional information or have any questions, Jose Garcia, Office of Audit and Compliance Interim Deputy Director, serves as lead staff on this matter and can be reached by phone at 512-927-7454 or by email at jose.garcia@hhsc.state.tx.us.

Sincerely,

A black rectangular redaction box covering the signature of Phil Wilson.

Phil Wilson

P.O. Box 13247 • Austin, Texas 78711-3247 • 512-424-6500 • hhs.texas.gov

Texas Health and Human Services Commission (HHSC)
June 8, 2020 Management Response to the
U.S. Department of Health and Human Services Office of Inspector General
Draft Report dated April 6, 2020 - A-06-18-07001

***"Audit of Aspects of Texas' Quality Incentive Payment Program (QIPP)
Raise Questions About Its Ability to Promote Economy and Efficiency in the
Medicaid Program"***

Introduction to the Management Response

The Texas Health and Human Services Commission (HHSC) appreciates the opportunity to respond. Before responding to the individual recommendations, HHSC would first like to comment on the U.S. Department of Health and Human Services Office of Inspector General's (DHHS-OIG) finding that nursing facilities received less than half of earned incentive payments. DHHS-OIG reports that further analysis could determine whether a payment structure that ensures nursing facilities receive a greater share of incentive payments may promote economy and efficiency in Medicaid. Although DHHS-OIG did not provide a recommendation that directly addresses this finding, HHSC elects to respond to the underlying issue.

First, there are no federal regulations that restrict the amount of funds a nursing facility owner can or should retain. When a non-state governmental entity (NSGE) acquires a nursing facility, the NSGE owner takes on more than just the nursing facility's assets; as far as the regulating agency is concerned, the NSGE owner is the party responsible for the well-being of the facility's residents. NSGE owners can help nursing facilities with rising costs and improve quality and access to care for residents. Furthermore, NSGE owners can provide additional clinical support, oversight and educational opportunities for the nursing facility operations and staff.

Second, HHSC is unaware of a reason why ownership of a nursing facility by an NSGE should be treated differently in this regard than other ownership arrangements. For instance, when a hospital system with multiple facilities acquires a hospital, the system can use the revenues generated by that hospital in any way it deems fit. Medicaid revenues, once realized by a health system, can be deployed however the system desires. As DHHS-OIG reports, federal regulations do not dictate how QIPP payments must be used by the NSGE, Non-State Government Organization (NSGO) facilities, or privately-owned facilities.

Management Response Recommendation 1

Recommendation 1: CMS recover \$737,944 federal share of QIPP payments funded by IGTs derived from impermissible sources (a bank promissory note of \$800,000 and a line of credit of \$500,000) in the amount of \$1,300,000.

Statement of Concurrence or Nonconcurrence

HHSC does not concur with this recommendation and requests that it be removed from the report.

Discussion

HHSC disagrees with this recommendation and urges DHHS-OIG to remove it from the final report.

According to the DHHS-OIG audit team, intergovernmental transfers (IGTs) provided by two NSGEs were impermissible as the nonfederal share of QIPP funding. This conclusion was based on information provided by the NSGEs indicating they borrowed funds prior to making IGTs to the state for QIPP. One NSGE obtained \$800,000 through a commercial loan agreement. The other NSGE obtained \$500,000 through an existing line of credit. DHHS-OIG has not alleged that, but for the debt instrument, the NSGEs would not have had sufficient revenue to fund the QIPP IGT either at the time of the transfer or at all throughout the course of the fiscal year.¹ DHHS-OIG has simply taken the position that loan funds cannot be used as the non-federal share of QIPP payments. DHHS-OIG has, therefore, concluded that the IGT was from an impermissible funding source.² However, this position is not supported by CMS regulation or policy, and there is no legal basis or precedent for the position.

1. DHHS-OIG's reading of 42 C.F.R. §433.51 is incorrect.

DHHS-OIG has based its position on 42 C.F.R. §433.51, which provides that public funds may be considered as the non-federal share in claiming Federal Financial Participation (FFP) if the public funds are appropriated directly to

¹ See Ex. 1, Email from Tony A. Rawlins, DHHS-OIG, to Cristy Olufsen and others at HHSC, responding to HHSC requests for additional information and support regarding the DHHS-OIG's IGT finding (July 25, 2019).

² Ex. 1.

the state or local Medicaid agency or are transferred from other public agencies to the State or local agency and are under its administrative control. Part 433 does not define “public funds.”

The language of the regulation does not support DHHS-OIG’s recommendation to CMS. On the contrary, the plain language of the regulation permits the state to accept loan funds as the non-federal share. The loan funds transferred from the governmental entities were public funds because they were in the hands of the local governmental entity when they were transferred to HHSC.³

Moreover, DHHS-OIG’s position is inconsistent with the Social Security Act. 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” 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, such as loans, are not permitted.

2. The state had no notice of prohibition.

The state has had no notice of a regulation or policy that would support DHHS-OIG’s recommended prohibition on accepting loan funds as IGT. If CMS intends to impose a condition on the grant of federal moneys, it must do so unambiguously.⁴ Yet DHHS-OIG has identified no definition of “public funds” to support its position. Further, the requirement currently codified in §433.51 has been in regulation for at least 40 years, but the state has found no instance of CMS interpreting “public funds” to exclude loan funds.⁵

³ There does not seem to be a question that the funds were transferred from the local governmental entity to the State Medicaid agency, and DHHS-OIG has not alleged that the funds were not under HHSC’s control.

⁴ *Hawaii Department of Human Services et al*, Ruling on Request for Reconsideration, DAB 1981, issued February 22, 2006 (citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17 (1981)).

⁵ To the contrary, there are at least two instances of CMS or OIG identifying loan funds as the source of IGT, but in neither case are the loan funds the basis for an adverse finding. See, *Review of the Commonwealth of Pennsylvania’s Use of Intergovernmental Transfers to Finance Medicaid Supplementation Payments to County Nursing Facilities* (A-03-00-00203) (February 9, 2001); *New Hampshire Department of Health and Human Services*, DAB Decision No. 1862, 2003.

3. HHSC rule does not prohibit loan funds as IGT.

Title 1 of the Texas Administrative Code (TAC) §353.1301 provides the definition of “public funds” that is relevant to the state’s directed payment programs, including QIPP. According to this rule, “public funds” are:

Funds derived from taxes, assessments, levies, and investments. Public funds also include other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

DHHS-OIG asserts that funding derived from a debt instrument cannot be IGT because debt instruments do not fall within the state’s definition of public funds. However, DHHS-OIG’s interpretation of the rule is incorrect. First, while the definition lists certain types of funds that are considered public in nature (i.e., “[f]unds derived from taxes, assessments, levies, and investments”) the list is not exclusive. Second, the definition goes on to provide that “[p]ublic funds also include other public revenues within the sole and unrestricted control of a governmental entity.”⁶ Common definitions of “revenue” and “public revenue” would include loan funds. Therefore, loan funds received by these NSGEs to cover temporary cash needs can be public funds pursuant to the state’s definition in §353.1301.

A. FASB and GASB

When HHSC asked DHHS-OIG staff if they relied on a particular definition of public revenues, DHHS-OIG staff provided Financial Accounting Standards Board (FASB) standards, arguing that they support the idea that loans cannot be considered public revenues. However, the document provided by DHHS-OIG says that it does not apply to governmental units.⁷

⁶ DHHS-OIG does not seem to be alleging that the funds were not in the “sole and unrestricted control” of the governmental entity. In fact, the records of the loans provided by the NSGEs and relied on by DHHS-OIG do not indicate that the loan funds were restricted in any way. The rule also provides that public funds do not include “gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.” DHHS-OIG does not seem to be arguing that the funds constitute any of these items.

⁷ “Financial reporting by state and local governmental units is within the purview of the Governmental Accounting Standards board (GASB), and the FASB has not considered the applicability of this Statement to those units.” Page 6-7, footnote 2.

DHHS-OIG also provided Governmental Accounting Standards Series Statement No. 33 for the proposition that a loan cannot constitute revenue, highlighting the sentence, “Most governments receive a large portion of their revenues through nonexchange transactions, including income, sales, and property taxes; intergovernmental grants, entitlements, and other financial assistance; and private donations.” This document is not instructive because Statement No. 33 relates to nonexchange transactions, and loans are not nonexchange transactions.

B. The state interprets “public revenue” to include loan funds

A similar definition of “public funds” appears in the Texas Medicaid State Plan. Specifically, the state plan provides that public funds include “public revenues within the sole and unrestricted control of the governmental entity....”⁸ It is well settled that a state has the authority to interpret its own state plan, as long as that interpretation is reasonable, gives effect to the language of the plan as a whole, and is supported by evidence of consistent administrative practice.⁹ Texas interprets the term “public revenues” to include loan funds in the context of the state plan, and there is no basis to impose a different interpretation on similar rule language.

Conclusion

DHHS-OIG’s audit finding that loan funds are not a permissible source of IGT is not supported by CMS regulation or policy. Moreover, DHHS-OIG’s interpretation of the state’s definition of public funds is incorrect. Accordingly, the state urges DHHS-OIG to exclude the finding and associated recommendation from the audit report.

Management Response to Recommendation 2

Recommendation 2: CMS re-evaluate Texas’ QIPP to ensure that it operates in a manner that meets program objectives while promoting economy and efficiency in Medicaid.

⁸ Texas State Plan Under Title XIX of the Social Security Act Medical Assistance Program, Attachment 4.19-D, p. 16.

⁹ *New Jersey Department of Human Resources*, DAB Decision No. 2107, 2007.

Statement of Concurrence or Nonconcurrence

HHSC concurs with this recommendation.

Action Plan

Summary - Texas HHSC believes QIPP currently operates in a manner that promotes economy and efficiency in Medicaid. HHSC is transforming its healthcare delivery system to value-based care, increasingly linking provider payments to measures of quality. With the introduction of QIPP in September 2017, HHSC made performance on certain quality measures a basis for providers to earn incentive payments. HHSC continues to monitor and assess performance and make improvements to strengthen the program on an ongoing basis.

To further advance value-based care and improve quality and innovation in the provision of nursing facility services, Texas expanded the QIPP quality metrics beginning in State Fiscal Year (SFY) 2020 (effective September 1, 2019). The enhanced incentive criteria, developed in collaboration with stakeholders, include staffing and other new metrics that require more effort on the part of providers to attain.

Quality of QIPP-participating nursing facilities generally rated below average - QIPP draws from across Texas' pool of nursing facilities, and the quality of participating nursing facilities reflects a cross-section of Texas providers. More than 99% of eligible facilities have enrolled to participate in the upcoming SFY 2021 program year. Facilities with lower performance on CMS 5-Star Quality Ratings are most in need of improvement, and HHSC encourages enrollment in QIPP to promote improvement.

HHSC has recognized staffing issues as a significant contributor to lower CMS quality ratings for some Texas facilities. Therefore, improving staffing was a central focus for QIPP quality metric development and HHSC implemented three quality measures related directly to staffing for the SFY 2020 and SFY 2021 program years. Data gathered through the current staffing measures will be used to inform future quality measure selection and development.

SFY 2018 Nursing facilities that declined in performance continued to receive quality improvement incentive payments - Despite not showing facility-specific incremental quality improvement, some nursing

facilities qualified for incentive payments by performing better than the national average.

By program year 3 (SFY 2020), after the audit period, HHSC had already taken steps to raise the performance standards for participating providers. For SFY 2020 - 2021, HHSC requires facilities to achieve higher performance levels than in prior years to begin earning incentive payments. On September 1, 2021, HHSC will incorporate quality measures informed by previous years of program data and impact evaluations.

HHSC removed a program requirement that allowed NFs to earn partial incentive payments for "moderate improvement" on one component; improvement on all Minimum Data Set metrics is now measured against only the "strong improvement" scale. For SFYs 2022 - 2023, HHSC will assess its use of the national average as an alternative performance target.

Texas will evaluate preliminary data from each program year individually and, in two-year cycles, will conduct more robust impact studies and quality metric changes, as needed. HHSC is performing an impact study on SFY 2018 and SFY 2019. The methodology combines Years 1 and 2 (SFY 2018-2019) and compares outcomes from participating facilities against those of non-participating facilities (in effect, a control group). A preliminary evaluation of SFY 2020 will be conducted when Minimum Data Set control data becomes available, allowing for a comprehensive impact study of SFY 2020-2021. Findings from the OIG audit will be added as comparison criteria for this review.

HHSC plans to convene a workgroup of internal and external stakeholders to redefine and expand quality metrics for the SFY 2022 program year, to take effect on September 1, 2021. In its selection of measures, development of benchmarks, and other program changes for the SFY 2022 and 2023 program years, HHSC will include the OIG recommendations in the group's work to continue improving the program's efficacy.

The Texas Administrative Code, §353.1302, requires the state to publish draft quality metrics for any given program year by December 31 of the calendar year before the beginning of the eligibility period and to publish final quality metrics by February 1 of the calendar year in which the new eligibility period begins.

HHSC Management Response – Texas QIPP

June 8, 2020

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Responsible Manager

Andy Vasquez, Medicaid and CHIP Services (MCS) Deputy Associate
Commissioner, Quality and Program Improvement

Responsible Party for Providing Status Updates

Sylvia Addison, MCS Audit Coordinator, Quality and Program Improvement

Target Implementation Date

September 1, 2021

APPENDIX F: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: November 17, 2020

TO: Christi Grimm
Principal Deputy Inspector General

FROM: Seema Verma 
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Aspects of Texas' Quality Incentive Payment Program Raise Questions about Its Ability to Promote Economy and Efficiency in the Medicaid Program (A-06-18-07001)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that Texas' Quality Incentive Payment Program (QIPP) meets program objectives and promotes economy and efficiency in the Medicaid program.

Within a managed care delivery system, states have the option to implement certain delivery system and provider payment initiatives under Medicaid managed care contracts, including those with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs). These types of payment arrangements, collectively referred to as "state directed payments," permit states to direct, via contract requirements, specific payments made by managed care plans to providers under certain circumstances in order to assist states in furthering the goals and priorities of their Medicaid programs. Currently, all state directed payments included in Medicaid managed care contracts under 42 C.F.R. § 438.6(c) require prior approval and must be based on the utilization and delivery of services to Medicaid beneficiaries covered under the contract. In addition, these state directed payment arrangements are expected to advance at least one of the goals and objectives in the state's quality strategy and be directed equally, using the same terms of performance across a class of providers. Further, provider participation in these state directed payments cannot be conditioned upon the provider entering into or adhering to intergovernmental transfer (IGT) agreements.

During CMS' review and approval process, which has been implemented through a required preprint submission from states to CMS, the agency reviews all information related to the payment arrangements, including the financing of state directed managed care payments. In 2017, CMS approved Texas' preprint submission to include state directed payments to nursing facilities in their Medicaid managed care contracts. The goal was to encourage nursing facilities to improve the quality and innovation of their services, and improvement is based on several quality measures that are collected by CMS.

Since 2017, CMS has communicated to Texas that more robust documentation to demonstrate that the state directed payments result in provider payment rates that are reasonable, appropriate, and attainable would be required for future preprint submissions. Specifically, CMS communicated to the state that its documentation must provide the average base rate paid by plans to providers absent the impact of state directed payments, the effect each state directed payment(s) has on reimbursement for the service type(s), and any additional effects of

permissible pass-through payments on reimbursement using a standardized measure. CMS also indicated that the documentation must be specific to each service type included in the state directed payment (e.g., nursing facility services) and specific to each provider class identified (e.g., non-state government owned nursing facilities and private nursing facilities). Further, CMS made the state aware that the allocation of certain QIPP funds continued to raise concerns about the link of the payments to utilization, delivery of services, or quality under the contract, and that CMS expects the state to update future QIPP submissions to better align the payments with regulatory requirements.

CMS recently approved the payment arrangement for the rating period covering September 1, 2020 through August 31, 2021 (state fiscal year (SFY) 2021), with the understanding that the state would submit an updated quality strategy to CMS no later than May 2021. Within the approval letter for the payment arrangement for SFY 2021, CMS outlined recommendations and requirements associated with this arrangement in future preprint submissions. As the OIG notes in its report, in response to CMS communications, Texas has already made modifications to the QIPP quality metrics, including the addition of metrics addressing infection control and staffing in nursing homes. One area of critical focus is infection control and CMS has also outlined an expectation that the state include additional quality measures in future preprint submissions. In addition, CMS has communicated that the state must also include an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy in accordance with 42 C.F.R. § 438.6(c)(2). Moreover, within the approval letter for the SFY 2021 payment arrangement, CMS required that the state provide complete SFY 2020 evaluation results with the submission of the SFY 2022 preprint.

In its report, the OIG identifies two intergovernmental transfers (IGTs) that are used to fund the non-Federal share of Texas' QIPP payments. While section 1903(w)(6)(A) of the Social Security Act (the Act) specifically permits state and local units of government to share in financing the Medicaid program through IGTs and certified public expenditures (CPEs), CMS notes that IGTs must be derived from permissible sources consistent with section 1903(w) of the Act and 42 CFR Part 433 subpart B. To further strengthen these requirements, in November 2019, CMS issued the proposed Medicaid Fiscal Accountability Rule (CMS-2393-P) which, if finalized as proposed, would clearly limit permissible state or local funds that may be considered as the state share to state general fund dollars appropriated by the state legislature, IGTs from units of government (including Indian tribes) derived from state or local taxes, or funds appropriated to state university teaching hospitals. CMS recently withdrew the final rule from the regulatory agenda and will use this time to further consider the public comments received.

Aside from specific communications and technical assistance provided to the State of Texas, CMS has undertaken a number of efforts to ensure all states with managed care programs understand CMS regulations and policies with respect to state directed payments. In November 2017, CMS published an informational bulletin,¹ a related appendix with examples of payment arrangements,² and a 42 CFR § 438.6(c) preprint³ for states to use when requesting CMS approval of state directed payments under 42 C.F.R. § 438.6(c). In May 2020, CMS also published guidance⁴ outlining Medicaid Managed Care Options in responding to the COVID-19 public health emergency. In addition, CMS is currently updating guidance with respect to state directed payments and the § 438.6(c) preprint based on experience with states on implementing

¹ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf>

² <https://www.medicaid.gov/sites/default/files/2020-02/appendix-a.pdf>

³ <https://www.medicaid.gov/sites/default/files/2020-02/438-preprint.pdf>

⁴ <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf>

state directed payments over the last three years. Overall, CMS has reviewed and approved more than 400 state directed payment arrangements since this part of the 2016 managed care final rule took effect beginning with contract rating periods on or after July 1, 2017. To further assist states, CMS is working to provide additional guidance to:

- Clarify existing policy and alleviate burden faced by states by proactively addressing common questions that arise during the preprint review;
- Enhance program integrity in the use of state directed payments; and
- Remind states of the quality-related requirements that must be met to secure CMS approval.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Work with Texas to determine whether the source of the IGTs and the practice of using debt instruments to fund the nonfederal share of QIPP payments meets program objectives and promotes economy and efficiency in Medicaid

CMS Response

CMS concurs with this recommendation. CMS will work with Texas to determine whether the IGTs used to fund the nonfederal share of QIPP payments were from permissible sources consistent with section 1903(w) of the Social Security Act and 42 CFR Part 433 subpart B.

OIG Recommendation

Reevaluate QIPP to ensure that it operates in a manner that meets program objectives while promoting economy and efficiency in Medicaid

CMS Response

CMS reevaluates most state directed payment arrangements on an annual basis. Therefore, we will reevaluate the payment arrangement with the state's submission of the Year 5 (SFY 2022) preprint to ensure alignment with federal regulatory requirements for state directed payments as well as the recommendations and requirements CMS outlined in our approval of the SFY 2021 payment arrangement. As part of this reevaluation, CMS will also consider whether the allocation of certain QIPP funds continue to raise concerns about the link of the payments to utilization, delivery of services, or quality under the contract

As described above, CMS has already taken steps with the state to ensure that future QIPP submissions in the years subsequent to the period under OIG's review meet program objectives while promoting economy and efficiency in Medicaid. In addition, CMS is currently developing additional guidance to all states on state directed payments to further enhance program integrity, quality and state accountability.