

September 16, 2026

Ms. Stephanie Stephens
Chief Medicaid and CHIP Services Officer
State of Texas, Health and Human Services Commission
4601 W Guadalupe Street
MC H100
Austin, TX 78751

Dear Ms. Stephanie Stephens:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Texas's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on May 15, 2026, and a final revised preprint was received on August 19, 2026. The proposal has a control name of TX_VBP.Fee_IPH.OPH.BHI_Renewal_20260901-20270831.

CMS has completed our review of the following Medicaid managed care SDP(s):

- Comprehensive Hospital Increase Reimbursement Program (CHIRP), which has components consisting of both uniform increases and pay for performance for eligible hospitals, for the rating period covering September 1, 2026 through August 31, 2027, incorporated in the capitation rates through a risk-based rate adjustment up to \$9,148,763,141.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the [Medicaid Managed Care Rate Development Guide](#). The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

Based on CMS's preliminary determination, the SDP proposal with the control name of TX_VBP.Fee_IPH.OPH.BHI_Renewal_20250901-20260831 likely qualified for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of \$9,148,763,142 for the grandfathered SDP named TX_VBP.Fee_IPH.OPH.BHI_Renewal_20250901-20260831 submitted on May 6, 2025 (as specified in item 4 of the applicable SDP preprint form) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F.
GILES JR -S

Digitally signed by JOHN
F. GILES JR -S
Date: 2026.09.16
16:28:24 -04'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

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

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

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
September 1, 2026 - August 31, 2027
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* September 1, 2026
3. Identify the managed care program(s) to which this payment arrangement will apply:
STAR, STAR+PLUS and STAR Kids; see Attachment A for the risk groups associated with each program.
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: \$9,148,763,141
 - a. Identify the estimated federal share of this state directed payment: \$5,365,749,582
 - b. Identify the estimated non-federal share of this state directed payment: \$3,783,013,559

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

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

6. If this is not the initial submission for this state directed payment, please indicate if:
- a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.
 - b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.
 - i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
State Fiscal Years 2017 through 2026
 - c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
 - ☐ Payment Type Change
 - ☐ Provider Type Change
 - ☒ Quality Metric(s) / Benchmark(s) Change
 - ☒ Other; please describe:
- HHSC proposes the following CHIRP changes for SFY 2027: 1) Remove the following structure measures: a) C1-105: Health Information Exchange (HIE) Participation b) C1-163: NMDOH Screening and Follow-up Plan Best F
- ☐ No changes from previously approved preprint other than rating period(s).
7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

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

The Comprehensive Hospital Increase Reimbursement Program (CHIRP) is comprised of three financial components: the Uniform Hospital Rate Increase Payment (UHRIP), the Average Commercial Incentive Award (ACIA) component, and the Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA) component. Funds under the Comprehensive Hospital Increase Reimbursement Program (CHIRP) will be paid to managed care organizations (MCOs) through three components of the managed care per member per month (PMPM) capitation rates.

The MCOs' distribution of CHIRP funds to the enrolled hospitals under the UHRIP and ACIA components will be a directed uniform percentage rate increase above the negotiated rate. Enrolled hospitals will be paid based upon utilization/claims for services in the program period. A hospital must have provided at least one Medicaid service to a Medicaid client in each reporting period to be eligible for payments. In determining the percentage increases, HHSC will consider information provided by the participants in the service delivery area (SDA).

For hospitals participating in the APHRIQA component, HHSC will direct MCOs to pay eligible providers via a scorecard. The scorecard will direct the level of payment to be made based on the providers' achievements in the pay for performance measures as described in question 13b. HHSC will also consider:

* the class or classes of a hospital;

* the type of service or services;

- a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
- b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

Texas State Plan, Attachment 4.19-A for Inpatient Hospital Services and Attachment 4.19-B for Outpatient Hospital Services, located at:
<https://apps.hhs.texas.gov/documents/medicaid-chip-state-plan-attachments.pdf>

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

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

If checked, please answer all questions in Subsection IIA.

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

If checked, please answer all questions in Subsection IIB.

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

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

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

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

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

Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA) includes process and outcome measures to advance the goals and objectives of the Texas Managed Care Quality Strategy. Only urban and children's hospitals are eligible to participate in APHRIQA in SFY 2027. All APHRIQA measures are pay-for-performance. Participating hospitals will earn payment based on achievement of the measures that tie to quality strategy goals.

Hospitals participating in APHRIQA must annually submit data for the process and outcome measures to demonstrate progress in promoting optimal health; keeping patients free from harm; and promoting effective practices for people with chronic, complex, and serious conditions. APHRIQA payments are made based on performance demonstrating maintenance or improvement over baseline data using measurable targets, which are attributable to the performance by the providers delivering services to enrollees in each of Texas' managed care program(s) for which APHRIQA applies. The only exceptions are two measures, Catheter-Associated Urinary Tract Infection (CAUTI) and Pediatric Central Line-Associated Bloodstream Infection (CLABSI), which are measured at the hospital level due to measure steward (NHSSN) specifications for hospital safety measures and, therefore, cannot be stratified by managed care program.

Each hospital is assigned five outcome and process measures based on the hospital's class. Urban hospitals are assigned the following measures: 1) PSI 13 Postoperative Sepsis Rate; 2) Plan All-Cause Readmission; 3) Food Insecurity Screening and Follow-up Plan; 4) Safe Use of Opioids – Concurrent Prescribing; and 5) PC-02 Cesarean Section if the hospital has greater than or equal to 30 Medicaid managed care live births in calendar year 2025; otherwise they are assigned CAUTI.

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

TABLE 1: Payment Arrangement Provider Performance Measures

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

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

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

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

The goal calculation type for each measure is high benchmark, average benchmark, actual/expected (A/E) ratio, or improvement over self (IOS).

High benchmark measures (90th percentile or national goal) include PC-02 Cesarean Birth. Providers fully achieve the measure if: 1) performance is better than or equal to the high benchmark and better than, equal to, or worse than the provider-specific baseline; or 2) performance meets or exceeds a 5% gap closure over the provider-specific baseline. Providers partially achieve the measure if the provider-specific baseline is worse than the high benchmark and performance is worse than the high benchmark and equal to or better than the provider-specific baseline.

Average benchmark measures (50th percentile or average) include PSI 13 Postoperative Sepsis Rate, Plan All-Cause Readmission (PCR-AD), Pediatric CLABSI, Pediatric All-Condition Readmissions, and Follow-up After ED Visit for Mental Illness: Ages 6-17. Providers fully achieve the measure if: 1) performance is better than or equal to the average benchmark and better than the provider-specific baseline; or 2) performance meets or exceeds a 5% gap closure over the provider-specific baseline. Providers partially achieve the measure if: 1) if the provider-specific baseline is better than or equal to the benchmark: performance is better than or equal to the benchmark and worse than or equal to the provider-specific baseline; or 2) if the provider-specific baseline is worse than the benchmark: performance is worse than the benchmark and equal to or better than the provider-specific baseline.

A/E ratio measures include Catheter-Associated Urinary Tract Infection (CAUTI). Providers fully achieve the measure if: 1) performance is below or equal to .8 and better than, equal to, or worse than the provider-specific baseline; 2) performance is below 1 and better than the provider-specific baseline; or 3) performance meets or exceeds a 5% gap closure over the provider-specific baseline. Providers partially achieve the measure if: 1) performance is below 1 and equal to or worse than the provider-specific baseline; or 2) performance is equal to or above 1 and equal to or better than the provider-specific baseline.

IOS measures include Food Insecurity Screening and Follow-up Plan, Safe Use of Opioids – Concurrent Prescribing, and Preventive Care and Screening: Screening for Depression and Follow-Up Plan. Providers fully achieve the measure if performance meets or exceeds a 10% gap closure over the provider-specific baseline. Providers partially achieve the measure if performance is equal to or better than the provider-specific baseline.

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

Each hospital is assigned five outcome and process measures based on the hospital's class. Urban hospitals are assigned the following measures: 1) PSI 13 Postoperative Sepsis Rate; 2) Plan All-Cause Readmission; 3) Food Insecurity Screening and Follow-up Plan; 4) Safe Use of Opioids – Concurrent Prescribing; and 5) PC-02 Cesarean Section if the hospital has greater than or equal to 30 Medicaid managed care live births in calendar year 2025; otherwise it is assigned CAUTI.

Children's hospitals are assigned the following measures: 1) Pediatric CLABSI; 2) Pediatric All-Condition Readmission; 3) Follow-up After ED Visit for Mental Illness; 4) Food Insecurity Screening and Follow-up Plan; and 5) Preventive Care and Screening: Screening for Depression and Follow-up Plan.

Each outcome and process measure has a performance target and a point value. Each outcome measure has a point value of four, and each process measure has a point value of two.

Hospitals whose 12-month performance meets or exceeds a measure's performance target earn the measure's full point value. Hospitals whose performance partially meets a measure's performance target earn half of the measure's point value.

The sum of the point values of a hospital's assigned measures is the total points the hospital can earn. A hospital's payment tier is determined by the percentage of total available points the hospital earned.

There are four payment tiers:

- Tier 1: $\geq 50\%$ of points earned (8-16 points out of 16 total points) – 100% payment
- Tier 2: $\geq 40\%$ of points earned (7 points out of 16 total points) – 80% payment
- Tier 3: $\geq 20\%$ of points earned (4-6 points out of 16 total points) – 40% payment
- Tier 4: $< 20\%$ of points earned (0-3 points out of 16 total points) – 0% payment

If a hospital has no denominator volume for a measure in the performance period, the total points available to that hospital will be reduced by the point value of the measure for which they have no denominator volume.

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

HHSC developed the specifications for this process measure by researching existing and emerging literature and best practices about food insecurity screening tools and follow-up planning.

For this state-developed measure, CHIRP-participating providers must use the Hunger Vital Sign food insecurity tool or another standardized, age-appropriate food insecurity screening tool.

The Hunger Vital Sign is a validated two-question food insecurity screening tool. It identifies households as being at risk for food insecurity if they answer that either or both of the following two statements is 'often true' or 'sometimes true' (vs. 'never true'):

- "Within the past 12 months we worried whether our food would run out before we got money to buy more."
- "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

The pairing of the two questions has been validated for high rates of sensitivity and specificity (up to 97 and 83 percent, respectively) for accurately identifying food insecurity among pediatric, adolescent, and adult populations (Hager et al., 2010). The two questions come from the U.S. Department of Agriculture (USDA) U.S. Household Food Security Survey Module (18 total questions), which is considered the gold standard for identifying households at risk of food insecurity.

In addition to its validity, brevity, and age-appropriateness for Medicaid managed care members, HHSC selected the Hunger Vital Sign tool because it is the most common food insecurity screening tool used by stakeholders according to the Social Needs Screening Tool Comparison Table compiled by the University of California San Francisco Social Interventions Research & Evaluation Network (University of San Francisco California Social Interventions Research & Evaluation Network, 2025). For example, the CMS Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) tool, the American Academy of Family Physicians Social Drivers of Health tool, and many electronic health record vendor systems, including Epic, use the Hunger Vital Sign as their food insecurity screening tool (Hunger Vital Sign™ National Community of Practice, 2025; Health Care Without Harm, 2025; Cacciaglia, 2021).

References

- 1) Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Cook, J. T., Ettinger de Cuba, S. E., Casey, P. H., Chilton, M., Cutts, D. B., Meyers A. F., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. *Pediatrics*, 126(1), 26-32. doi:10.1542/peds.2009-3146.
- 2) University of San Francisco California Social Interventions Research & Evaluation Network (2025, January). Social Needs Screening Tool Comparison Table. <https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison>.
- 3) Hunger Vital Sign™ National Community of Practice (2025, January). Hunger Vital Sign™ National Community of Practice.
- 4) https://childrenshealthwatch.org/wp-content/uploads/Hunger-Vital-Sign-National-Community-of-Practice_goals-priorities-accomplishments.pdf.
- 5) Health Care Without Harm (2025, January). Delivering Community Benefit: Healthy food playbook. Food insecurity screening – Health care's role in identifying food insecurity. <https://foodcommunitybenefit.noharm.org/resources/implementation-strategy/food-insecurity-screening>.
- 6) Cacciaglia, A. (2021, September 13). Food as Medicine: Addressing Hunger in the Community. <https://www.epicshare.org/share-and-learn/food-as-medicine-addressing-hunger-in-the-community>.

14. Is the State seeking a multi-year approval of the state directed payment arrangement?

☐ Yes ☒ No

- a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.
- b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

CHIRP has been moving towards pay-for-performance since its inception in SFY 2022. For the first three years of the program (SFY 2022 – SFY 2024), providers worked to build capacity to report quality metrics as a condition of participation in the program. In SFY 2025, Texas added a pay-for-performance program component for urban and children's hospitals. That program component continued in SFY 2026 and will further continue in SFY 2027.

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

- a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.
- b. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.
- c. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.
- d. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

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

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

- a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates*¹ (42 C.F.R. § 438.6(c)(1)(iii)(B))
- b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))
- c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

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

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

- a.** Check the basis for the fee schedule selected above.
 - i.** ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). ²
 - ii.** ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.
 - iii.** ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.
 - 1.** If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)
- b.** Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

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

- a.** ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- b.** Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.
- c.** Indicate the number of exemptions to the requirement:
 - i.** Expected in this contract rating period (estimate)
 - ii.** Granted in past years of this payment arrangement
- d.** Describe how such exemptions will be considered in rate development.

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

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

- a. Will the state require plans to pay a ☐ uniform dollar amount or a ☒ uniform percentage increase? (*Please select only one.*)
- b. What is the magnitude of the increase (e.g., \$4 per claim or 3% increase per claim?)
- c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

Please refer to the "Q19 - Increase by Class " and " Q19 – Increase by Hospital" tabs of Attachment B.

The percentage increase will be uniform for hospitals within a class in a service delivery area, but increases may vary between hospitals due to the choice to participate in the optional ACIA component; hospitals not participating in ACIA will have a 0% ACIA rate. After determining the percentage increases (process described in 19d below), HHSC will modify its contracts with the managed care organizations (MCOs) in the service delivery area (SDA) to direct the percentage increases beginning the first day of the program period. Each program period is equal to the state fiscal year, beginning September 1st and ending August 31st. Percentage increases will remain consistent throughout the program year and will be paid at the time of claim adjudication.

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

The CHIRP includes two percentage increase components: UHRIP and ACIA. The total value of the UHRIP component means the total estimated payments for UHRIP. The total dollars in the UHRIP component are equal to a percentage of the Medicare UPL gap not to exceed 100% and capped at the ACR UPL gap to avoid exceeding 100% of the applicable average commercial rate for the total rate payment analysis. Allocation of funds across hospital classes will be proportional to the combined Medicare gap of each hospital class within an SDA to the total Medicare gap of all hospital classes within the SDA. The Medicare gap is calculated separately for STAR inpatient, STAR PLUS inpatient, STAR Kids inpatient, STAR outpatient, STAR PLUS outpatient, and STAR Kids outpatient services and is aggregated by SDA and class. For example: if the inpatient STAR Medicare gap for a class and SDA totaled \$1 million and the percentage of the Medicare gap was set to 100%, the total inpatient STAR UHRIP value would be set to \$1 million. If the class and SDA had \$5 million in estimated inpatient STAR encounters, the inpatient STAR rate would be 20% (\$1 million divided by \$5 million). The total value of the ACIA component will be equal to a percentage of the Average Commercial Rate (ACR) gap, less payments received under UHRIP. The ACIA rate increase percentage is calculated separately for STAR inpatient, STAR PLUS inpatient, STAR Kids inpatient, STAR outpatient, STAR PLUS outpatient, and STAR Kids outpatient services at the individual hospital level not to exceed 95% of the SDA/class aggregate ACR. Allocation of funds across hospital classes will be proportional to the combined ACR gap of each hospital class within an SDA to the total ACR gap of all hospital classes within the SDA.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

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

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

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

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

Provider classes are defined on a per SDA basis. Classes of participating hospitals include children ' s hospitals, rural hospitals, state-owned hospitals that are not institutions for mental diseases (IMDs), urban hospitals, non-state-owned IMDs, and state-owned IMDs. SDAs in the state are Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, MRSA Central, MRSA Northeast, MRSA West, Nueces, Tarrant, and Travis.

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

The following classes are defined on a per SDA basis.

Children's hospital A Medicaid hospital designated by Medicare as a children's hospital. (See Texas State Plan, Attachment 4.19-A, Page 1a)

Rural hospital A hospital enrolled as a Medicaid provider that:
is located in county with 68,750 or fewer persons according to the 2020 U.S. Census;
is designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or
meets all of the following:
i) has 100 or fewer beds;
ii) is designated by Medicare as a CAH, SCH, or RRC; and
iii) is located in an MSA. (see Texas State Plan, Attachment 4.19-A, Page 3)

State-owned non-IMD hospital A hospital owned and operated by a state university or other state agency that is not primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental disease. (See Texas State Plan, Attachment 4.19-A, Pages 3a)

Urban hospital Hospital located in a metropolitan statistical area and not fitting the definition of rural hospitals, children's hospitals, state-owned teaching hospitals, or freestanding psychiatric hospitals. (See Texas State Plan, Attachment 4.19-A, Page 4)

Non-state-owned IMDs (a.k.a. "Free-standing psychiatric hospital") A non-state-owned IMD providing inpatient psychiatric hospital services to individuals under the age of 21 and inpatient hospital services to individuals 65 years or older. (See Texas State Plan, Attachment 4.19-A, Page 10e)

State-owned IMDs A state-owned IMD providing inpatient psychiatric hospital services to individuals under the age of 21 and inpatient hospital services to individuals 65 years or older. (See Texas State Plan, Attachment 4.19-A, Page 10e) Noted deviations from the Texas State Plan The University of Texas Southwestern hospital is a state-owned acute care hospital, but it is not currently included in the definition of "State Teaching Hospital" in the state plan. However, we are including UT Southwestern in the State-owned non-IMD hospital class with the other state teaching hospitals because the state ownership structure makes this classification appropriate. We have also distinguished Non-State-owned IMDs from State-Owned IMDs because non-state-owned IMDs are paid for inpatient services using a per diem rate methodology, whereas state-owned IMDs are paid for inpatient services using a TEPPA-based methodology. Due to the differences in their underlying reimbursement rate methodology, we feel that separate classes are appropriate. The program also incorporates geographic boundaries that align with the managed care service delivery areas to distinguish hospital classes rather than defining the classes on a statewide basis as is the case in the state plan. Texas believes it is appropriate to use the established SDAs in the program because it is solely operated in managed care. This approach will allow Texas to work with the MCOs to ensure that the rate increases are targeted to the hospitals in each SDA to best incentivize the goals and objectives of the program. All State Plan Attachments <https://apps.bhs.texas.gov/documents/medicaid-chip-state-plan-attachments.pdf>

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

HHSC will determine the percentage increase applicable to one or more classes of hospital by program component. The total value of the UHRIP component will be equal to a percentage of the estimated Medicare gap on a per-class basis, capped at the ACR UPL gap to avoid exceeding 100% of the applicable average commercial rate for the total payment rate analysis. Allocation of funds across hospital classes will be proportional to the combined Medicare gap of each hospital class within an SDA to the total Medicare gap of all hospital classes within the SDA.

The total value of the ACIA component will be equal to a percentage of the ACR gap on a per-class basis, less payments received under UHRIP, not to exceed 95% of the SDA/class aggregate ACR.

The total value of the APHRIQA component will be equal to the sum of a percentage of the Medicare gap, not to exceed 100 percent, on a per class basis, capped at the ACR UPL gap to avoid exceeding 100% of the applicable average commercial rate for the total payment rate analysis less the amount received in the UHRIP component, and a percentage of the total estimated ACR UPL, not to exceed 95 percent, on a per-class basis less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA and less any payments received under ACIA. After determining the percentage of rate increase, HHSC will modify its contracts with the MCOs in the SDA to direct the percentage rate increases. HHSC will direct Managed Care Organizations (MCOs) to pay APHRIQA component payments to providers in accordance with the method described in questions 11 and 13 via scorecard.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:
- a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).
 - b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).
 - c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).
23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

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

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

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
<i>Ex: Rural Inpatient Hospital Services</i>	<i>80%</i>	<i>20%</i>	<i>N/A</i>	<i>N/A</i>	<i>100%</i>
a. See Tables 2.A in the addendum for inpatient and outpatient payment analysis.					
b.					
c.					
d.					
e.					
f.					
g.					

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

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

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

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

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

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

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

The payments were compared to the Average Commercial Rate as demonstrated in the ACR demonstration. The Average Commercial Rate (ACR) demonstration is based on the hospital's self-reported total commercial payments divided by their total commercial charges for the hospital fiscal year ending in calendar year 2024, multiplied by Medicaid charges from state fiscal year 2024 with a trend factor based on the weighted average of the actuarial factors from 2024 to 2026 and a caseload adjustment from 2026 to 2027. New hospitals in a class and SDA of one used annualized Medicaid charges from state fiscal year 2024. In state fiscal year 2027, Driscoll Children's Hospital – Rio Grande Valley (Driscoll RGV) was the only new hospital in a class and SDA of one that used the annualized Medicaid charges from state fiscal year 2024. The actual Medicaid charges from state fiscal year 2024 only reflected data from June 20, 2024 to August 31, 2024, so Driscoll RGV's charges were divided by 70 and multiplied by 365 to reflect an annualized total. The resulting product of the ACR payment to charge ratio and the trended Medicaid charges is then summed by hospital class and compared to total Medicaid payments for the class, including the projected state fiscal year 2027 Medicaid base payments prior to CHIRP, the estimated state fiscal year 2026 Network Access Improvement Program (NAIP) payments, and then the estimated state fiscal year 2027 CHIRP payments are included in the state directed payments columns. Each table adds an additional component to CHIRP to show the cumulative effect of the program payments.

CHIRP preprint addendum Table 2.A Explanations:

Please refer to the “Table 2.A Summary” tab of Attachment B for a summary of the data included in each table. “Table 2.A Summary” lists each table name for each of the 18 separate payment level demonstrations, and whether the ACR UPL and payment data is for inpatient or outpatient and for STAR, STAR PLUS, or STAR Kids. There are a total of 6 categories (Inpatient STAR, Inpatient STAR PLUS, Inpatient STAR Kids, Outpatient STAR PLUS, and Outpatient STAR Kids). The next few columns of the chart includes a summary of what payments are being compared to the ACR UPL in each table 2.A exhibit: Medicaid Payments before CHIRP, NAIP Payments, UHRIP Payments, ACIA Payments, and/or APHRIQA Payments. The chart is split into three sections – (1) payments including UHRIP, (2) payments including UHRIP and ACIA, and (3) payments for all CHIRP components (UHRIP, ACIA, and APHRIQA). For example – the first line of the chart is for Table 2.A.1 Inpatient STAR UHRIP Payment Levels Compared to ACR. It compares the inpatient STAR ACR upper payment limit (UPL) sum by rate class and service delivery area (SDA) to the inpatient STAR Medicaid payments before CHIRP, after inpatient STAR UHRIP, and after the Network Access Improvement Program (NAIP) pass-through payments. All CHIRP-participating hospitals in the SDA/class for inpatient STAR are included in the inpatient STAR total. The final column is the inpatient STAR Medicaid base payment, the inpatient STAR UHRIP payment, and the STAR NAIP payment summed and then divided by the inpatient STAR ACR UPL. Every class that has an inpatient STAR UHRIP payment in the MCO program stays at or under 100 percent of the class's inpatient STAR ACR. Classes with a total payment level greater than 100 percent were ineligible for an inpatient STAR UHRIP payment and were removed from the table.

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

The total value of the UHRIP component will be equal to a percentage not to exceed 100% of the estimated Medicare gap on a per-class basis, capped at the ACR UPL gap to avoid exceeding 100% of the applicable average commercial rate for the total payment rate analysis. The total value of the ACIA component will be equal to a percentage not to exceed 100% of the ACR gap on a per-class basis, less payments received under UHRIP. The ACIA payment is further reduced, so total CHIRP payments plus other Medicaid payments do not exceed 95% of the ACR upper payment limit at the SDA/class level. The value of the APHRIQA component will be equal to the sum of a percentage of the Medicare gap, not to exceed 100%, on a per-class basis, capped at the ACR UPL gap on a per-class basis to avoid exceeding 100% of the applicable average commercial rate for the total payment rate analysis less the amount received in the UHRIP component, and a percentage of the total estimated ACR UPL, not to exceed 95%, on a per class basis less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA and less any payments received under ACIA.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

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

a. If yes:

- i.** What is/are the state-assigned identifier(s) of the contract actions provided to CMS?
- ii.** Please indicate where (page or section) the state directed payment is captured in the contract action(s).

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

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

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

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

- 30.** Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☒ No
- a.** If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.
7/17/2026
- b.** If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

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

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

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

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

- a. ☒ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- b. ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- c. ☐ Other, please describe:

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

N/A

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

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

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

- a. ☐ State general revenue
- b. ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- c. ☒ Health Care-Related Provider tax(es) / assessment(s)
- d. ☐ Provider donation(s)
- e. ☐ Other, specify:

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

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

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Please see Addendum Table 4.A.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

- b.** ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
- c.** Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

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

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

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

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

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the “75/75” test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Please see Addendum Table 5.A						
ii.						
iii.						
iv.						
v.						

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

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

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

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

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

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

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, “In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340.”
40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:
- a. A hyperlink to State’s most recent quality strategy: <https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality>
 - b. The effective date of quality strategy. September 27, 2024
41. If the State is currently updating the quality strategy, please submit a draft version, and provide:
- a. A target date for submission of the revised quality strategy (month and year):
 - b. Note any potential changes that might be made to the goals and objectives.

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

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

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

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

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

Through the CHIRP program, the State aims to promote optimal health, keep patients free from harm, promote effective practices for people with chronic, complex and serious conditions, and use high quality health information to make data driven decisions. CHIRP includes hospitals that provide a variety of services to Medicaid clients. HHSC will analyze information reported by participating hospitals to evaluate CHIRP's impact in a number of areas, including health information exchange, maternal care, hospital safety, care transitions, and rural preventive care.

The program includes three components: Uniform Hospital Rate Increase Program (UHRIP), Average Commercial Incentive Award (ACIA), and Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA). Hospitals apply to participate in the program and can opt into the ACIA and APHRIQA components.

UHRIP includes a structure and an outcome measure. It requires yearly submission of status updates for the structure measures and data for the outcome measure. All CHIRP-participating hospitals must participate in UHRIP. All measures in UHRIP must be reported as a condition of participation by each hospital unless otherwise noted.

ACIA includes structure, process, and outcome measures. It requires yearly submission of status updates for the structure measure and data for the process and outcome measures. ACIA measures are grouped into modules around a similar hospital service type. For some modules, a hospital will only report if the hospital has provided the module's specific type of service. Within each ACIA module being reported, a hospital must report all the measures for which the hospital is eligible as a condition of participation in ACIA.

APHRIQA measures are used to pay providers on a pay-for-performance basis. APHRIQA includes process and outcome measures. It requires yearly submission of data for the process and outcome measures. The Texas Health and Human Services Commission (HHSC) determines, on an annual basis, the classes of hospitals that are eligible to participate in APHRIQA. For SFY 2027, urban and children's hospitals will be eligible to participate in APHRIQA.

Hospitals that participate in APHRIQA but do not participate in ACIA will be required to also report on certain ACIA measures necessary for program evaluation.

For structure measures, a hospital must submit responses to qualitative reporting questions that summarize their progress toward implementing the structure measure. Hospitals are not required to implement structure measures as a condition of reporting or program participation.

For outcome and process measures, a hospital must submit specified numerator and denominator data and respond to qualitative reporting questions as specified by HHSC. Hospitals must report data for most measures stratified by all-payer and Medicaid managed care.

Reported qualitative and numeric data will be used to determine pay-for-performance measure achievement and monitor hospital-level progress toward state quality objectives. The process, outcome, and structure measures that will be used to evaluate CHIRP and advance the goals and objectives identified in Table 7 are included in the "Evaluation Plan for Four State Directed Payment Programs."

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

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

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

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes ¹
<i>Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039</i>	<i>CY 2019</i>	<i>34%</i>	<i>Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year</i>	<i>Example notes</i>
i. Please refer to the Evaluation Plan for Four State Directed Payment Programs (Evaluation Performance Targets section)				
ii.				
iii.				
iv.				

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

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

Please refer to the Evaluation of Four State Directed Payment Programs.

PREPRINT SUBSECTION IIA: VALUE-BASED PAYMENT/DELIVERY SYSTEM REFORM
ADDENDUM TABLE 1.A. PAYMENT ARRANGEMENT PROVIDER PERFORMANCE MEASURES

Directions 1. In Table 1.A below, use the rows to add more measure(s) to Table 1 that the State will tie to provider performance under this value-based payment or delivery system reform arrangement (provider performance measures). States may also use Table 1.A in lieu of completing Table 1 in the preprint. Input data only in beige cells in columns B - H.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 1 in the preprint, please delete Tabs 2.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 1.A: Payment Arrangement Provider Performance Measures

Column1	Measure Name and NQF # (if applicable)	Measure Steward/Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target	Notes
Data Format	Free text	Set values (select one)	Year (CY or FY YYYY)	Percent (#.##%)	Free text	Percent (#.##%)	Free text
			Baseline year must be added after the first year of the payment arrangement	Baseline percentage must be added after the first year of the payment arrangement	If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment		If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here
Example:	Percent of High-Risk Residents with Pressure Ulcers - Long Stay	Centers for Medicare & Medicaid Services	CY 2018	9.23%	Year 2	8.00%	
a.	PC-02 Cesarean Birth	The Joint Commission (TJC)	CY 2025	0.222	CY 2026	23.6% benchmark or IOS 5%	Urban hospital measure
b.	Catheter-Associated Urinary Tract Infection (CAUTI)	Centers for Disease Control and Prevention	CY 2025	0.000	CY 2026	0.8 or below 1 and better than baseline or IOS 5%	Urban hospital measure
c.	PSI 13 Postoperative Sepsis Rate	Centers for Medicare & Medicaid Services (CMS)	CY 2025	0.000	CY 2026	4.18 per 1000 discharges benchmark and better than baseline or IOS 5%	Urban hospital measure
d.	Plan All-Cause Readmission (PCR-AD)	National Committee for Quality Assurance	CY 2025	7.692	CY 2026	12.0 per 100 discharges benchmark and better than baseline or IOS 5%	Urban hospital measure; hospitals will report the observed rate of readmissions to the same hospital
							Urban and children's hospital measure; Numerator - Patients screened for food insecurity using the Hunger Vital Sign food insecurity screening tool or another standardized, age-appropriate food insecurity screening tool with the screening results documented during the current encounter or during the previous twelve months, AND if the most recent screening result is positive, a follow-up plan is documented within 30 days of the positive screening result. Denominator - All attributed patients with an eligible encounter during the measurement period.
e.	Food Insecurity Screening and Follow-up Plan	Texas Health and Human Services Commission	CY 2025	0.243	CY 2026	IOS 10%	
g.	Safe Use of Opioids - Concurrent Prescribing	CMS	CY 2025	0.077	CY 2026	IOS 10%	Urban hospital measure
h.	Pediatric Central Line-Associated Bloodstream Infection (CLABSI)	Children's Hospital's Solutions for Patient Safety (CHSPS)	CY 2025	0.699	CY 2026	0.912 per 1000 central-line days and better than baseline or IOS 5%	Children's hospital measure
i.	Pediatric All-Condition Readmission	Center of Excellence for Pediatric Quality Measurement (CEPQM)	CY 2025	5.600	CY 2026	5.75 per 100 discharges	Children's hospital measure; hospitals will report the observed rate of readmissions to the same hospital
j.	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS	CY 2025	0.189	CY 2026	IOS 10%	Children's hospital measure
k.	Follow-Up After ED Visit for Mental Illness: Ages 6-17	CMS	CY 2024	0.639	CY 2026	56.31% benchmark and better than baseline or IOS 5%	Children's hospital measure
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 2. in the preprint, please delete Tabs 1.A and 3.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 2.A.1 Inpatient STAR UHRIP Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass- Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Inpatient STAR Children's Bexar	49.4%	50.4%	0.0%	0.0%	99.8%
b.	Inpatient STAR Children's Dallas	39.4%	60.3%	0.0%	0.0%	99.7%
c.	Inpatient STAR Children's El Paso	36.5%	1.5%	0.0%	0.0%	37.9%
d.	Inpatient STAR Children's Harris	31.5%	68.4%	0.0%	0.0%	100.0%
e.	Inpatient STAR Children's Lubbock	40.9%	2.9%	0.0%	0.0%	43.8%
f.	Inpatient STAR Children's Nueces	25.4%	69.7%	0.0%	0.0%	95.1%
g.	Inpatient STAR Children's Tarrant	27.9%	27.4%	0.0%	0.0%	55.3%
h.	Inpatient STAR Children's Travis	27.5%	38.2%	0.0%	0.0%	65.7%
i.	Inpatient STAR Non-state-owned IMD Bexar	68.8%	2.8%	0.0%	0.0%	71.6%
j.	Inpatient STAR Non-state-owned IMD Dallas	56.3%	38.3%	0.0%	0.0%	94.6%
k.	Inpatient STAR Non-state-owned IMD El Paso	78.5%	6.3%	0.0%	0.0%	84.7%
l.	Inpatient STAR Non-state-owned IMD Harris	70.4%	29.6%	0.0%	0.0%	100.0%
m.	Inpatient STAR Non-state-owned IMD Lubbock	88.3%	11.5%	0.0%	0.0%	99.7%
n.	Inpatient STAR Non-state-owned IMD MRSA Central	70.7%	29.0%	0.0%	0.0%	99.6%
o.	Inpatient STAR Non-state-owned IMD MRSA West	75.2%	23.3%	0.0%	0.0%	98.6%
p.	Inpatient STAR Non-state-owned IMD Tarrant	67.7%	28.4%	0.0%	0.0%	96.1%
q.	Inpatient STAR Non-state-owned IMD Travis	70.2%	29.5%	0.0%	0.0%	99.7%
r.	Inpatient STAR Rural Bexar	87.0%	12.2%	0.0%	0.0%	99.2%
s.	Inpatient STAR Rural Jefferson	23.9%	76.0%	0.0%	0.0%	99.8%
t.	Inpatient STAR Rural Lubbock	95.5%	3.8%	0.0%	0.0%	99.3%
u.	Inpatient STAR Rural MRSA Central	77.1%	18.5%	0.0%	0.0%	95.6%
v.	Inpatient STAR Rural MRSA Northeast	71.8%	9.3%	0.0%	0.0%	81.1%
w.	Inpatient STAR Rural Nueces	75.3%	24.1%	0.0%	0.0%	99.4%
x.	Inpatient STAR Rural Tarrant	39.4%	5.1%	0.0%	0.0%	44.5%
y.	Inpatient STAR Rural Travis	70.0%	1.4%	0.0%	0.0%	71.4%
z.	Inpatient STAR State-owned IMD MRSA West	36.6%	63.3%	0.0%	0.0%	99.9%
aa.	Inpatient STAR State-owned Non-IMD Dallas	28.9%	71.0%	0.0%	0.0%	99.9%
bb.	Inpatient STAR State-owned Non-IMD Harris	49.3%	35.0%	0.0%	0.0%	84.3%
cc.	Inpatient STAR Urban Bexar	29.0%	50.1%	0.0%	5.1%	84.2%
dd.	Inpatient STAR Urban Dallas	20.7%	54.6%	0.0%	3.2%	78.6%
ee.	Inpatient STAR Urban El Paso	22.9%	28.7%	0.0%	8.3%	59.9%
ff.	Inpatient STAR Urban Harris	21.3%	76.8%	0.0%	1.8%	99.9%
gg.	Inpatient STAR Urban Hidalgo	25.4%	70.8%	0.0%	0.0%	96.2%
hh.	Inpatient STAR Urban Jefferson	27.8%	68.3%	0.0%	0.0%	96.1%
ii.	Inpatient STAR Urban Lubbock	31.3%	14.4%	0.0%	22.6%	68.3%
jj.	Inpatient STAR Urban MRSA Central	31.5%	44.4%	0.0%	0.0%	75.9%
kk.	Inpatient STAR Urban MRSA Northeast	26.7%	40.3%	0.0%	0.0%	67.0%
ll.	Inpatient STAR Urban MRSA West	27.7%	25.7%	0.0%	4.0%	57.4%
mm.	Inpatient STAR Urban Nueces	29.1%	37.0%	0.0%	7.5%	73.6%
nn.	Inpatient STAR Urban Tarrant	24.8%	49.1%	0.0%	0.0%	73.9%
oo.	Inpatient STAR Urban Travis	33.5%	21.4%	0.0%	0.0%	54.9%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.2 Inpatient STAR PLUS UHRIP Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Inpatient STAR PLUS Children's Bexar	4.4%	95.6%	0.0%	0.0%	100.0%
b.	Inpatient STAR PLUS Children's Dallas	21.4%	78.6%	0.0%	0.0%	100.0%
c.	Inpatient STAR PLUS Children's Harris	18.2%	81.7%	0.0%	0.0%	100.0%
d.	Inpatient STAR PLUS Children's Lubbock	9.9%	33.9%	0.0%	0.0%	43.8%
e.	Inpatient STAR PLUS Children's Nueces	2.7%	92.5%	0.0%	0.0%	95.2%
f.	Inpatient STAR PLUS Children's Tarrant	21.3%	31.8%	0.0%	0.0%	53.1%
g.	Inpatient STAR PLUS Children's Travis	18.2%	47.1%	0.0%	0.0%	65.3%
h.	Inpatient STAR PLUS Rural Bexar	33.9%	50.2%	0.0%	0.0%	84.0%
i.	Inpatient STAR PLUS Rural Hidalgo	40.6%	25.6%	0.0%	0.0%	66.2%
j.	Inpatient STAR PLUS Rural Jefferson	63.4%	36.1%	0.0%	0.0%	99.5%
k.	Inpatient STAR PLUS Rural Lubbock	50.8%	48.8%	0.0%	0.0%	99.6%
l.	Inpatient STAR PLUS Rural MRSA Central	71.1%	19.2%	0.0%	0.0%	90.3%
m.	Inpatient STAR PLUS Rural MRSA Northeast	77.8%	7.8%	0.0%	0.0%	85.6%
n.	Inpatient STAR PLUS Rural Nueces	80.6%	4.8%	0.0%	0.0%	85.4%
o.	Inpatient STAR PLUS State-owned Non-IMD Dallas	29.8%	70.0%	0.0%	0.0%	99.7%
p.	Inpatient STAR PLUS State-owned Non-IMD Harris	54.3%	29.9%	0.0%	0.0%	84.2%
q.	Inpatient STAR PLUS Urban Bexar	27.4%	51.2%	0.0%	0.2%	78.8%
r.	Inpatient STAR PLUS Urban Dallas	21.6%	57.4%	0.0%	0.0%	79.0%
s.	Inpatient STAR PLUS Urban El Paso	17.7%	55.3%	0.0%	0.0%	73.0%
t.	Inpatient STAR PLUS Urban Harris	28.5%	62.7%	0.0%	0.0%	91.1%
u.	Inpatient STAR PLUS Urban Hidalgo	28.4%	56.8%	0.0%	0.0%	85.2%
v.	Inpatient STAR PLUS Urban Jefferson	23.1%	69.7%	0.0%	0.0%	92.8%
w.	Inpatient STAR PLUS Urban Lubbock	15.4%	40.4%	0.0%	1.2%	57.0%
x.	Inpatient STAR PLUS Urban MRSA Central	32.6%	45.0%	0.0%	0.0%	77.5%
y.	Inpatient STAR PLUS Urban MRSA Northeast	31.6%	36.0%	0.0%	0.0%	67.5%
z.	Inpatient STAR PLUS Urban MRSA West	23.4%	34.7%	0.0%	0.0%	58.1%
aa.	Inpatient STAR PLUS Urban Nueces	32.1%	44.4%	0.0%	2.1%	78.6%
bb.	Inpatient STAR PLUS Urban Tarrant	21.1%	60.5%	0.0%	0.0%	81.6%
cc.	Inpatient STAR PLUS Urban Travis	27.5%	31.3%	0.0%	0.0%	58.8%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.3 Inpatient STAR Kids UHRIP Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Inpatient STAR Kids Children's Bexar	39.8%	60.2%	0.0%	0.0%	100.0%
b.	Inpatient STAR Kids Children's Dallas	41.7%	58.0%	0.0%	0.0%	99.8%
c.	Inpatient STAR Kids Children's El Paso	29.5%	8.6%	0.0%	0.0%	38.1%
d.	Inpatient STAR Kids Children's Harris	34.0%	65.7%	0.0%	0.0%	99.7%
e.	Inpatient STAR Kids Children's Nueces	29.3%	65.8%	0.0%	0.0%	95.1%
f.	Inpatient STAR Kids Children's Tarrant	23.9%	31.3%	0.0%	0.0%	55.3%
g.	Inpatient STAR Kids Children's Travis	32.4%	34.3%	0.0%	0.0%	66.7%
h.	Inpatient STAR Kids Non-state-owned IMD Dallas	39.5%	47.8%	0.0%	0.0%	87.3%
i.	Inpatient STAR Kids Non-state-owned IMD Harris	60.5%	27.8%	0.0%	0.0%	88.3%
j.	Inpatient STAR Kids Non-state-owned IMD Lubbock	88.8%	10.7%	0.0%	0.0%	99.5%
k.	Inpatient STAR Kids Non-state-owned IMD MRSA West	65.3%	30.7%	0.0%	0.0%	95.9%
l.	Inpatient STAR Kids Non-state-owned IMD Nueces	87.4%	12.2%	0.0%	0.0%	99.6%
m.	Inpatient STAR Kids Non-state-owned IMD Tarrant	88.3%	4.4%	0.0%	0.0%	92.7%
n.	Inpatient STAR Kids Non-state-owned IMD Travis	83.8%	15.9%	0.0%	0.0%	99.7%
o.	Inpatient STAR Kids Rural Jefferson	9.1%	90.9%	0.0%	0.0%	99.9%
p.	Inpatient STAR Kids Rural MRSA Northeast	41.6%	44.5%	0.0%	0.0%	86.1%
q.	Inpatient STAR Kids Rural Nueces	53.4%	27.2%	0.0%	0.0%	80.7%
r.	Inpatient STAR Kids Rural Tarrant	5.6%	38.8%	0.0%	0.0%	44.5%
s.	Inpatient STAR Kids State-owned IMD El Paso	38.3%	61.3%	0.0%	0.0%	99.7%
t.	Inpatient STAR Kids State-owned IMD Hidalgo	27.5%	49.0%	0.0%	0.0%	76.5%
u.	Inpatient STAR Kids State-owned IMD MRSA West	44.6%	55.3%	0.0%	0.0%	99.9%
v.	Inpatient STAR Kids State-owned Non-IMD Dallas	33.2%	66.8%	0.0%	0.0%	100.0%
w.	Inpatient STAR Kids State-owned Non-IMD Harris	70.1%	14.0%	0.0%	0.0%	84.1%
x.	Inpatient STAR Kids Urban Bexar	33.9%	66.1%	0.0%	0.0%	99.9%
y.	Inpatient STAR Kids Urban Dallas	19.4%	39.0%	0.0%	0.0%	58.4%
z.	Inpatient STAR Kids Urban El Paso	20.8%	43.4%	0.0%	0.0%	64.2%
aa.	Inpatient STAR Kids Urban Harris	24.9%	52.4%	0.0%	0.0%	77.3%
bb.	Inpatient STAR Kids Urban Hidalgo	31.7%	68.2%	0.0%	0.0%	100.0%
cc.	Inpatient STAR Kids Urban Jefferson	37.2%	62.5%	0.0%	0.0%	99.7%
dd.	Inpatient STAR Kids Urban Lubbock	24.8%	42.4%	0.0%	0.0%	67.2%
ee.	Inpatient STAR Kids Urban MRSA Central	47.2%	29.7%	0.0%	0.0%	76.9%
ff.	Inpatient STAR Kids Urban MRSA Northeast	26.9%	37.4%	0.0%	0.0%	64.3%
gg.	Inpatient STAR Kids Urban MRSA West	39.8%	23.5%	0.0%	0.0%	63.3%
hh.	Inpatient STAR Kids Urban Nueces	28.3%	43.9%	0.0%	0.0%	72.3%
ii.	Inpatient STAR Kids Urban Tarrant	26.9%	64.3%	0.0%	0.0%	91.2%
jj.	Inpatient STAR Kids Urban Travis	17.4%	49.5%	0.0%	0.0%	66.8%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 2. in the preprint, please delete Tabs 1.A and 3.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 2.A.4 Outpatient STAR UHRIP Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Outpatient STAR Children's Bexar	23.6%	56.5%	0.0%	0.0%	80.1%
b.	Outpatient STAR Children's Dallas	80.8%	18.6%	0.0%	0.0%	99.3%
c.	Outpatient STAR Children's El Paso	26.2%	41.1%	0.0%	0.0%	67.3%
d.	Outpatient STAR Children's Harris	53.0%	39.2%	0.0%	0.0%	92.1%
e.	Outpatient STAR Children's Lubbock	26.0%	34.8%	0.0%	0.0%	60.8%
f.	Outpatient STAR Children's Tarrant	43.3%	28.6%	0.0%	0.0%	71.9%
g.	Outpatient STAR Children's Travis	29.4%	70.5%	0.0%	0.0%	99.8%
h.	Outpatient STAR Rural Dallas	40.5%	2.4%	0.0%	0.0%	42.9%
i.	Outpatient STAR Rural Travis	58.3%	4.1%	0.0%	0.0%	62.4%
j.	Outpatient STAR State-owned Non-IMD Dallas	25.2%	36.9%	0.0%	0.0%	62.1%
k.	Outpatient STAR State-owned Non-IMD Harris	66.7%	10.0%	0.0%	0.0%	76.7%
l.	Outpatient STAR Urban Bexar	60.2%	39.7%	0.0%	0.0%	99.9%
m.	Outpatient STAR Urban Dallas	36.3%	55.1%	0.0%	0.0%	91.4%
n.	Outpatient STAR Urban El Paso	42.7%	57.2%	0.0%	0.0%	99.9%
o.	Outpatient STAR Urban Harris	68.2%	31.4%	0.0%	0.0%	99.5%
p.	Outpatient STAR Urban Hidalgo	57.8%	42.2%	0.0%	0.0%	100.0%
q.	Outpatient STAR Urban Jefferson	47.1%	52.7%	0.0%	0.0%	99.8%
r.	Outpatient STAR Urban Lubbock	52.6%	46.9%	0.0%	0.0%	99.5%
s.	Outpatient STAR Urban MRSA Central	38.5%	61.2%	0.0%	0.0%	99.6%
t.	Outpatient STAR Urban MRSA Northeast	35.0%	49.6%	0.0%	0.0%	84.6%
u.	Outpatient STAR Urban MRSA West	37.4%	34.1%	0.0%	0.0%	71.5%
v.	Outpatient STAR Urban Nueces	48.3%	51.2%	0.0%	0.0%	99.5%
w.	Outpatient STAR Urban Tarrant	49.7%	50.2%	0.0%	0.0%	99.8%
x.	Outpatient STAR Urban Travis	41.3%	58.3%	0.0%	0.0%	99.6%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.5 Outpatient STAR PLUS UHRIP Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (#.##%)	Percent (#.##%)	Percent (#.##%) or N/A	Percent (#.##%) or N/A	Percent (#.##%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Outpatient STAR PLUS Children's Bexar	18.5%	61.2%	0.0%	0.0%	79.8%
b.	Outpatient STAR PLUS Children's Dallas	88.1%	11.5%	0.0%	0.0%	99.6%
c.	Outpatient STAR PLUS Children's El Paso	44.5%	22.7%	0.0%	0.0%	67.2%
d.	Outpatient STAR PLUS Children's Harris	43.3%	48.1%	0.0%	0.0%	91.4%
e.	Outpatient STAR PLUS Children's Lubbock	19.3%	47.6%	0.0%	0.0%	66.8%
f.	Outpatient STAR PLUS Children's Tarrant	46.3%	23.1%	0.0%	0.0%	69.4%
g.	Outpatient STAR PLUS Children's Travis	16.1%	83.8%	0.0%	0.0%	99.8%
h.	Outpatient STAR PLUS Rural Lubbock	73.3%	26.4%	0.0%	0.0%	99.7%
i.	Outpatient STAR PLUS Rural MRSA Northeast	83.5%	3.3%	0.0%	0.0%	86.8%
j.	Outpatient STAR PLUS Rural Travis	58.6%	1.2%	0.0%	0.0%	59.8%
k.	Outpatient STAR PLUS State-owned Non-IMD Dallas	35.7%	26.4%	0.0%	0.0%	62.2%
l.	Outpatient STAR PLUS State-owned Non-IMD Harris	61.9%	14.2%	0.0%	0.0%	76.2%
m.	Outpatient STAR PLUS Urban Bexar	58.9%	40.7%	0.0%	0.0%	99.6%
n.	Outpatient STAR PLUS Urban Dallas	33.6%	45.7%	0.0%	0.0%	79.2%
o.	Outpatient STAR PLUS Urban El Paso	65.8%	34.2%	0.0%	0.0%	100.0%
p.	Outpatient STAR PLUS Urban Harris	50.8%	48.8%	0.0%	0.0%	99.7%
q.	Outpatient STAR PLUS Urban Hidalgo	67.6%	32.4%	0.0%	0.0%	100.0%
r.	Outpatient STAR PLUS Urban Jefferson	42.9%	56.7%	0.0%	0.0%	99.6%
s.	Outpatient STAR PLUS Urban Lubbock	27.4%	65.2%	0.0%	0.0%	92.7%
t.	Outpatient STAR PLUS Urban MRSA Central	39.4%	60.2%	0.0%	0.0%	99.6%
u.	Outpatient STAR PLUS Urban MRSA Northeast	50.6%	49.1%	0.0%	0.0%	99.7%
v.	Outpatient STAR PLUS Urban MRSA West	29.5%	44.3%	0.0%	0.0%	73.8%
w.	Outpatient STAR PLUS Urban Nueces	69.8%	30.0%	0.0%	0.0%	99.9%
x.	Outpatient STAR PLUS Urban Tarrant	48.2%	51.6%	0.0%	0.0%	99.8%
y.	Outpatient STAR PLUS Urban Travis	55.2%	44.7%	0.0%	0.0%	99.9%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

Directions

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TABLE 2.A.6 Outpatient STAR Kids UHRIP Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass- Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (#.##%)	Percent (#.##%)	Percent (#.##%) or N/A	Percent (#.##%) or N/A	Percent (#.##%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Outpatient STAR Kids Children's Bexar	18.2%	57.5%	0.0%	0.0%	75.7%
b.	Outpatient STAR Kids Children's Dallas	58.0%	41.8%	0.0%	0.0%	99.8%
c.	Outpatient STAR Kids Children's El Paso	27.3%	35.7%	0.0%	0.0%	63.0%
d.	Outpatient STAR Kids Children's Harris	37.0%	49.6%	0.0%	0.0%	86.6%
e.	Outpatient STAR Kids Children's Lubbock	46.5%	6.5%	0.0%	0.0%	53.0%
f.	Outpatient STAR Kids Children's Tarrant	49.4%	14.3%	0.0%	0.0%	63.7%
g.	Outpatient STAR Kids Children's Travis	36.5%	63.5%	0.0%	0.0%	100.0%
h.	Outpatient STAR Kids Rural Tarrant	48.3%	4.3%	0.0%	0.0%	52.6%
i.	Outpatient STAR Kids State-owned Non-IMD Dallas	29.4%	32.6%	0.0%	0.0%	62.0%
j.	Outpatient STAR Kids State-owned Non-IMD Harris	71.7%	5.0%	0.0%	0.0%	76.7%
k.	Outpatient STAR Kids Urban Bexar	63.7%	35.7%	0.0%	0.0%	99.4%
l.	Outpatient STAR Kids Urban Dallas	27.7%	53.1%	0.0%	0.0%	80.8%
m.	Outpatient STAR Kids Urban El Paso	40.3%	35.1%	0.0%	0.0%	75.4%
n.	Outpatient STAR Kids Urban Harris	88.5%	11.5%	0.0%	0.0%	100.0%
o.	Outpatient STAR Kids Urban Hidalgo	68.8%	19.3%	0.0%	0.0%	88.0%
p.	Outpatient STAR Kids Urban Jefferson	54.2%	17.9%	0.0%	0.0%	72.0%
q.	Outpatient STAR Kids Urban Lubbock	30.9%	43.5%	0.0%	0.0%	74.3%
r.	Outpatient STAR Kids Urban MRSA Central	36.9%	27.7%	0.0%	0.0%	64.6%
s.	Outpatient STAR Kids Urban MRSA Northeast	39.3%	19.3%	0.0%	0.0%	58.6%
t.	Outpatient STAR Kids Urban MRSA West	34.5%	29.0%	0.0%	0.0%	63.6%
u.	Outpatient STAR Kids Urban Nueces	45.4%	34.1%	0.0%	0.0%	79.5%
v.	Outpatient STAR Kids Urban Tarrant	59.3%	30.3%	0.0%	0.0%	89.6%
w.	Outpatient STAR Kids Urban Travis	55.7%	39.5%	0.0%	0.0%	95.2%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.7 Inpatient STAR UHRIP + ACIA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Inpatient STAR Children's Bexar	49.4%	50.4%	0.0%	0.0%	99.8%
b.	Inpatient STAR Children's Dallas	39.4%	60.3%	0.0%	0.0%	99.7%
c.	Inpatient STAR Children's El Paso	36.5%	32.5%	0.0%	0.0%	69.0%
d.	Inpatient STAR Children's Harris	31.5%	68.4%	0.0%	0.0%	100.0%
e.	Inpatient STAR Children's Hidalgo	34.5%	34.2%	0.0%	0.0%	68.7%
f.	Inpatient STAR Children's Lubbock	40.9%	27.8%	0.0%	0.0%	68.7%
g.	Inpatient STAR Children's Nueces	25.4%	69.7%	0.0%	0.0%	95.1%
h.	Inpatient STAR Children's Tarrant	27.9%	41.1%	0.0%	0.0%	69.0%
i.	Inpatient STAR Children's Travis	27.5%	41.2%	0.0%	0.0%	68.7%
j.	Inpatient STAR Non-state-owned IMD Bexar	68.8%	26.2%	0.0%	0.0%	95.0%
k.	Inpatient STAR Non-state-owned IMD Dallas	56.3%	38.3%	0.0%	0.0%	94.6%
l.	Inpatient STAR Non-state-owned IMD El Paso	78.5%	16.5%	0.0%	0.0%	94.9%
m.	Inpatient STAR Non-state-owned IMD Harris	70.4%	29.6%	0.0%	0.0%	100.0%
n.	Inpatient STAR Non-state-owned IMD Hidalgo	83.7%	10.9%	0.0%	0.0%	94.5%
o.	Inpatient STAR Non-state-owned IMD Lubbock	88.3%	11.5%	0.0%	0.0%	99.7%
p.	Inpatient STAR Non-state-owned IMD MRSA Central	70.7%	29.0%	0.0%	0.0%	99.6%
q.	Inpatient STAR Non-state-owned IMD MRSA West	75.2%	23.3%	0.0%	0.0%	98.6%
r.	Inpatient STAR Non-state-owned IMD Tarrant	67.7%	28.4%	0.0%	0.0%	96.1%
s.	Inpatient STAR Non-state-owned IMD Travis	70.2%	29.5%	0.0%	0.0%	99.7%
t.	Inpatient STAR Rural Bexar	87.0%	12.2%	0.0%	0.0%	99.2%
u.	Inpatient STAR Rural Dallas	51.8%	43.0%	0.0%	0.0%	94.8%
v.	Inpatient STAR Rural Hidalgo	76.7%	18.0%	0.0%	0.0%	94.7%
w.	Inpatient STAR Rural Jefferson	23.9%	76.0%	0.0%	0.0%	99.8%
x.	Inpatient STAR Rural Lubbock	95.5%	3.8%	0.0%	0.0%	99.3%
y.	Inpatient STAR Rural MRSA Central	77.1%	18.5%	0.0%	0.0%	95.6%
z.	Inpatient STAR Rural MRSA Northeast	71.8%	23.0%	0.0%	0.0%	94.8%
aa.	Inpatient STAR Rural Nueces	75.3%	24.1%	0.0%	0.0%	99.4%
bb.	Inpatient STAR Rural Tarrant	39.4%	55.6%	0.0%	0.0%	95.0%
cc.	Inpatient STAR Rural Travis	70.0%	24.5%	0.0%	0.0%	94.5%
dd.	Inpatient STAR State-owned IMD MRSA West	36.6%	63.3%	0.0%	0.0%	99.9%
ee.	Inpatient STAR State-owned Non-IMD Dallas	28.9%	71.0%	0.0%	0.0%	99.9%
ff.	Inpatient STAR State-owned Non-IMD Harris	49.3%	45.4%	0.0%	0.0%	94.7%
gg.	Inpatient STAR Urban Bexar	29.0%	50.1%	0.0%	5.1%	84.2%
hh.	Inpatient STAR Urban Dallas	20.7%	54.6%	0.0%	3.2%	78.6%
ii.	Inpatient STAR Urban El Paso	22.9%	37.6%	0.0%	8.3%	68.9%
jj.	Inpatient STAR Urban Harris	21.3%	76.8%	0.0%	1.8%	99.9%
kk.	Inpatient STAR Urban Hidalgo	25.4%	70.8%	0.0%	0.0%	96.2%
ll.	Inpatient STAR Urban Jefferson	27.8%	68.3%	0.0%	0.0%	96.1%
mm.	Inpatient STAR Urban Lubbock	31.3%	15.0%	0.0%	22.6%	68.9%
nn.	Inpatient STAR Urban MRSA Central	31.5%	44.4%	0.0%	0.0%	75.9%
oo.	Inpatient STAR Urban MRSA Northeast	26.7%	42.2%	0.0%	0.0%	68.9%
pp.	Inpatient STAR Urban MRSA West	27.7%	37.4%	0.0%	4.0%	69.0%
qq.	Inpatient STAR Urban Nueces	29.1%	37.0%	0.0%	7.5%	73.6%
rr.	Inpatient STAR Urban Tarrant	24.8%	49.1%	0.0%	0.0%	73.9%
ss.	Inpatient STAR Urban Travis	33.5%	35.2%	0.0%	0.0%	68.7%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.8 Inpatient STAR PLUS UHRIP + ACIA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Inpatient STAR PLUS Children's Bexar	4.4%	95.6%	0.0%	0.0%	100.0%
b.	Inpatient STAR PLUS Children's Dallas	21.4%	78.6%	0.0%	0.0%	100.0%
c.	Inpatient STAR PLUS Children's Harris	18.2%	81.7%	0.0%	0.0%	100.0%
d.	Inpatient STAR PLUS Children's Lubbock	9.9%	59.0%	0.0%	0.0%	68.9%
e.	Inpatient STAR PLUS Children's Nueces	2.7%	92.5%	0.0%	0.0%	95.2%
f.	Inpatient STAR PLUS Children's Tarrant	21.3%	47.6%	0.0%	0.0%	68.9%
g.	Inpatient STAR PLUS Children's Travis	18.2%	50.8%	0.0%	0.0%	69.0%
h.	Inpatient STAR PLUS Rural Bexar	33.9%	61.0%	0.0%	0.0%	94.9%
i.	Inpatient STAR PLUS Rural Dallas	67.4%	27.0%	0.0%	0.0%	94.4%
j.	Inpatient STAR PLUS Rural Hidalgo	40.6%	54.3%	0.0%	0.0%	94.9%
k.	Inpatient STAR PLUS Rural Jefferson	63.4%	36.1%	0.0%	0.0%	99.5%
l.	Inpatient STAR PLUS Rural Lubbock	50.8%	48.8%	0.0%	0.0%	99.6%
m.	Inpatient STAR PLUS Rural MRSA Central	71.1%	23.4%	0.0%	0.0%	94.5%
n.	Inpatient STAR PLUS Rural MRSA Northeast	77.8%	17.0%	0.0%	0.0%	94.9%
o.	Inpatient STAR PLUS Rural Nueces	80.6%	13.7%	0.0%	0.0%	94.2%
p.	Inpatient STAR PLUS Rural Tarrant	83.5%	10.9%	0.0%	0.0%	94.4%
q.	Inpatient STAR PLUS Rural Travis	92.1%	2.8%	0.0%	0.0%	94.9%
r.	Inpatient STAR PLUS State-owned Non-IMD Dallas	29.8%	70.0%	0.0%	0.0%	99.7%
s.	Inpatient STAR PLUS State-owned Non-IMD Harris	54.3%	40.2%	0.0%	0.0%	94.5%
t.	Inpatient STAR PLUS Urban Bexar	27.4%	51.2%	0.0%	0.2%	78.8%
u.	Inpatient STAR PLUS Urban Dallas	21.6%	57.4%	0.0%	0.0%	79.0%
v.	Inpatient STAR PLUS Urban El Paso	17.7%	55.3%	0.0%	0.0%	73.0%
w.	Inpatient STAR PLUS Urban Harris	28.5%	62.7%	0.0%	0.0%	91.1%
x.	Inpatient STAR PLUS Urban Hidalgo	28.4%	56.8%	0.0%	0.0%	85.2%
y.	Inpatient STAR PLUS Urban Jefferson	23.1%	69.7%	0.0%	0.0%	92.8%
z.	Inpatient STAR PLUS Urban Lubbock	15.4%	52.3%	0.0%	1.2%	68.9%
aa.	Inpatient STAR PLUS Urban MRSA Central	32.6%	45.0%	0.0%	0.0%	77.5%
bb.	Inpatient STAR PLUS Urban MRSA Northeast	31.6%	37.2%	0.0%	0.0%	68.8%
cc.	Inpatient STAR PLUS Urban MRSA West	23.4%	45.5%	0.0%	0.0%	68.9%
dd.	Inpatient STAR PLUS Urban Nueces	32.1%	44.4%	0.0%	2.1%	78.6%
ee.	Inpatient STAR PLUS Urban Tarrant	21.1%	60.5%	0.0%	0.0%	81.6%
ff.	Inpatient STAR PLUS Urban Travis	27.5%	41.5%	0.0%	0.0%	68.9%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions 2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.9 Inpatient STAR Kids UHRIP + ACIA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Inpatient STAR Kids Children's Bexar	39.8%	60.2%	0.0%	0.0%	100.0%
b.	Inpatient STAR Kids Children's Dallas	41.7%	58.0%	0.0%	0.0%	99.8%
c.	Inpatient STAR Kids Children's El Paso	29.5%	39.3%	0.0%	0.0%	68.8%
d.	Inpatient STAR Kids Children's Harris	34.0%	65.7%	0.0%	0.0%	99.7%
e.	Inpatient STAR Kids Children's Hidalgo	40.3%	28.6%	0.0%	0.0%	68.9%
f.	Inpatient STAR Kids Children's Nueces	29.3%	65.8%	0.0%	0.0%	95.1%
g.	Inpatient STAR Kids Children's Tarrant	23.9%	45.0%	0.0%	0.0%	68.9%
h.	Inpatient STAR Kids Children's Travis	32.4%	36.6%	0.0%	0.0%	69.0%
i.	Inpatient STAR Kids Non-state-owned IMD Bexar	90.2%	4.5%	0.0%	0.0%	94.7%
j.	Inpatient STAR Kids Non-state-owned IMD Dallas	39.5%	55.3%	0.0%	0.0%	94.8%
k.	Inpatient STAR Kids Non-state-owned IMD Harris	60.5%	34.5%	0.0%	0.0%	95.0%
l.	Inpatient STAR Kids Non-state-owned IMD Hidalgo	91.9%	2.8%	0.0%	0.0%	94.6%
m.	Inpatient STAR Kids Non-state-owned IMD Lubbock	88.8%	10.7%	0.0%	0.0%	99.5%
n.	Inpatient STAR Kids Non-state-owned IMD MRSA West	65.3%	30.7%	0.0%	0.0%	95.9%
o.	Inpatient STAR Kids Non-state-owned IMD Nueces	87.4%	12.2%	0.0%	0.0%	99.6%
p.	Inpatient STAR Kids Non-state-owned IMD Tarrant	88.3%	6.2%	0.0%	0.0%	94.5%
q.	Inpatient STAR Kids Non-state-owned IMD Travis	83.8%	15.9%	0.0%	0.0%	99.7%
r.	Inpatient STAR Kids Rural Hidalgo	75.6%	19.3%	0.0%	0.0%	94.8%
s.	Inpatient STAR Kids Rural Jefferson	9.1%	90.9%	0.0%	0.0%	99.9%
t.	Inpatient STAR Kids Rural MRSA Northeast	41.6%	53.3%	0.0%	0.0%	94.9%
u.	Inpatient STAR Kids Rural Nueces	53.4%	41.1%	0.0%	0.0%	94.6%
v.	Inpatient STAR Kids Rural Tarrant	5.6%	89.3%	0.0%	0.0%	95.0%
w.	Inpatient STAR Kids State-owned IMD El Paso	38.3%	61.3%	0.0%	0.0%	99.7%
x.	Inpatient STAR Kids State-owned IMD Hidalgo	27.5%	67.4%	0.0%	0.0%	94.9%
y.	Inpatient STAR Kids State-owned IMD MRSA West	44.6%	55.3%	0.0%	0.0%	99.9%
z.	Inpatient STAR Kids State-owned Non-IMD Dallas	33.2%	66.8%	0.0%	0.0%	100.0%
aa.	Inpatient STAR Kids State-owned Non-IMD Harris	70.1%	24.5%	0.0%	0.0%	94.6%
bb.	Inpatient STAR Kids Urban Bexar	33.9%	66.1%	0.0%	0.0%	99.9%
cc.	Inpatient STAR Kids Urban Dallas	19.4%	49.5%	0.0%	0.0%	68.9%
dd.	Inpatient STAR Kids Urban El Paso	20.8%	48.0%	0.0%	0.0%	68.8%
ee.	Inpatient STAR Kids Urban Harris	24.9%	52.4%	0.0%	0.0%	77.3%
ff.	Inpatient STAR Kids Urban Hidalgo	31.7%	68.2%	0.0%	0.0%	100.0%
gg.	Inpatient STAR Kids Urban Jefferson	37.2%	62.5%	0.0%	0.0%	99.7%
hh.	Inpatient STAR Kids Urban Lubbock	24.8%	44.1%	0.0%	0.0%	68.9%
ii.	Inpatient STAR Kids Urban MRSA Central	47.2%	29.7%	0.0%	0.0%	76.9%
jj.	Inpatient STAR Kids Urban MRSA Northeast	26.9%	42.0%	0.0%	0.0%	68.9%
kk.	Inpatient STAR Kids Urban MRSA West	39.8%	29.1%	0.0%	0.0%	68.9%
ll.	Inpatient STAR Kids Urban Nueces	28.3%	43.9%	0.0%	0.0%	72.3%
mm.	Inpatient STAR Kids Urban Tarrant	26.9%	64.3%	0.0%	0.0%	91.2%
nn.	Inpatient STAR Kids Urban Travis	17.4%	51.6%	0.0%	0.0%	68.9%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions 2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.10 Outpatient STAR UHRIP + ACIA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Outpatient STAR Children's Bexar	23.6%	56.5%	0.0%	0.0%	80.1%
b.	Outpatient STAR Children's Dallas	80.8%	18.6%	0.0%	0.0%	99.3%
c.	Outpatient STAR Children's El Paso	26.2%	42.7%	0.0%	0.0%	68.9%
d.	Outpatient STAR Children's Harris	53.0%	39.2%	0.0%	0.0%	92.1%
e.	Outpatient STAR Children's Lubbock	26.0%	42.9%	0.0%	0.0%	68.9%
f.	Outpatient STAR Children's Nueces	56.6%	11.9%	0.0%	0.0%	68.5%
g.	Outpatient STAR Children's Tarrant	43.3%	28.6%	0.0%	0.0%	71.9%
h.	Outpatient STAR Children's Travis	29.4%	70.5%	0.0%	0.0%	99.8%
i.	Outpatient STAR Rural Dallas	40.5%	54.3%	0.0%	0.0%	94.8%
j.	Outpatient STAR Rural Jefferson	74.1%	20.7%	0.0%	0.0%	94.8%
k.	Outpatient STAR Rural MRSA Northeast	92.2%	2.7%	0.0%	0.0%	94.9%
l.	Outpatient STAR Rural Tarrant	60.7%	34.0%	0.0%	0.0%	94.6%
m.	Outpatient STAR Rural Travis	58.3%	36.7%	0.0%	0.0%	95.0%
n.	Outpatient STAR State-owned Non-IMD Dallas	25.2%	69.7%	0.0%	0.0%	94.9%
o.	Outpatient STAR State-owned Non-IMD Harris	66.7%	28.0%	0.0%	0.0%	94.7%
p.	Outpatient STAR State-owned Non-IMD MRSA Northeast	64.5%	30.3%	0.0%	0.0%	94.8%
q.	Outpatient STAR Urban Bexar	60.2%	39.7%	0.0%	0.0%	99.9%
r.	Outpatient STAR Urban Dallas	36.3%	55.1%	0.0%	0.0%	91.4%
s.	Outpatient STAR Urban El Paso	42.7%	57.2%	0.0%	0.0%	99.9%
t.	Outpatient STAR Urban Harris	68.2%	31.4%	0.0%	0.0%	99.5%
u.	Outpatient STAR Urban Hidalgo	57.8%	42.2%	0.0%	0.0%	100.0%
v.	Outpatient STAR Urban Jefferson	47.1%	52.7%	0.0%	0.0%	99.8%
w.	Outpatient STAR Urban Lubbock	52.6%	46.9%	0.0%	0.0%	99.5%
x.	Outpatient STAR Urban MRSA Central	38.5%	61.2%	0.0%	0.0%	99.6%
y.	Outpatient STAR Urban MRSA Northeast	35.0%	49.6%	0.0%	0.0%	84.6%
z.	Outpatient STAR Urban MRSA West	37.4%	34.1%	0.0%	0.0%	71.5%
aa.	Outpatient STAR Urban Nueces	48.3%	51.2%	0.0%	0.0%	99.5%
bb.	Outpatient STAR Urban Tarrant	49.7%	50.2%	0.0%	0.0%	99.8%
cc.	Outpatient STAR Urban Travis	41.3%	58.3%	0.0%	0.0%	99.6%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.11 Outpatient STAR PLUS UHRIP + ACIA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Outpatient STAR PLUS Children's Bexar	18.5%	61.2%	0.0%	0.0%	79.8%
b.	Outpatient STAR PLUS Children's Dallas	88.1%	11.5%	0.0%	0.0%	99.6%
c.	Outpatient STAR PLUS Children's El Paso	44.5%	24.5%	0.0%	0.0%	69.0%
d.	Outpatient STAR PLUS Children's Harris	43.3%	48.1%	0.0%	0.0%	91.4%
e.	Outpatient STAR PLUS Children's Lubbock	19.3%	49.7%	0.0%	0.0%	69.0%
f.	Outpatient STAR PLUS Children's Nueces	52.2%	16.7%	0.0%	0.0%	68.9%
g.	Outpatient STAR PLUS Children's Tarrant	46.3%	23.1%	0.0%	0.0%	69.4%
h.	Outpatient STAR PLUS Children's Travis	16.1%	83.8%	0.0%	0.0%	99.8%
i.	Outpatient STAR PLUS Rural Bexar	76.4%	18.3%	0.0%	0.0%	94.7%
j.	Outpatient STAR PLUS Rural Dallas	64.8%	29.8%	0.0%	0.0%	94.7%
k.	Outpatient STAR PLUS Rural Hidalgo	93.8%	1.0%	0.0%	0.0%	94.8%
l.	Outpatient STAR PLUS Rural Jefferson	78.6%	15.8%	0.0%	0.0%	94.4%
m.	Outpatient STAR PLUS Rural Lubbock	73.3%	26.4%	0.0%	0.0%	99.7%
n.	Outpatient STAR PLUS Rural MRSA Northeast	83.5%	11.5%	0.0%	0.0%	95.0%
o.	Outpatient STAR PLUS Rural MRSA West	78.3%	16.2%	0.0%	0.0%	94.5%
p.	Outpatient STAR PLUS Rural Tarrant	54.0%	40.5%	0.0%	0.0%	94.6%
q.	Outpatient STAR PLUS Rural Travis	58.6%	36.3%	0.0%	0.0%	95.0%
r.	Outpatient STAR PLUS State-owned Non-IMD Dallas	35.7%	58.9%	0.0%	0.0%	94.7%
s.	Outpatient STAR PLUS State-owned Non-IMD Harris	61.9%	32.8%	0.0%	0.0%	94.8%
t.	Outpatient STAR PLUS State-owned Non-IMD MRSA Northeast	52.6%	42.1%	0.0%	0.0%	94.6%
u.	Outpatient STAR PLUS Urban Bexar	58.9%	40.7%	0.0%	0.0%	99.6%
v.	Outpatient STAR PLUS Urban Dallas	33.6%	45.7%	0.0%	0.0%	79.2%
w.	Outpatient STAR PLUS Urban El Paso	65.8%	34.2%	0.0%	0.0%	100.0%
x.	Outpatient STAR PLUS Urban Harris	50.8%	48.8%	0.0%	0.0%	99.7%
y.	Outpatient STAR PLUS Urban Hidalgo	67.6%	32.4%	0.0%	0.0%	100.0%
z.	Outpatient STAR PLUS Urban Jefferson	42.9%	56.7%	0.0%	0.0%	99.6%
aa.	Outpatient STAR PLUS Urban Lubbock	27.4%	65.2%	0.0%	0.0%	92.7%
bb.	Outpatient STAR PLUS Urban MRSA Central	39.4%	60.2%	0.0%	0.0%	99.6%
cc.	Outpatient STAR PLUS Urban MRSA Northeast	50.6%	49.1%	0.0%	0.0%	99.7%
dd.	Outpatient STAR PLUS Urban MRSA West	29.5%	44.3%	0.0%	0.0%	73.8%
ee.	Outpatient STAR PLUS Urban Nueces	69.8%	30.0%	0.0%	0.0%	99.9%
ff.	Outpatient STAR PLUS Urban Tarrant	48.2%	51.6%	0.0%	0.0%	99.8%
gg.	Outpatient STAR PLUS Urban Travis	55.2%	44.7%	0.0%	0.0%	99.9%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.12 Outpatient STAR Kids UHRIP + ACIA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Outpatient STAR Kids Children's Bexar	18.2%	57.5%	0.0%	0.0%	75.7%
b.	Outpatient STAR Kids Children's Dallas	58.0%	41.8%	0.0%	0.0%	99.8%
c.	Outpatient STAR Kids Children's El Paso	27.3%	41.7%	0.0%	0.0%	69.0%
d.	Outpatient STAR Kids Children's Harris	37.0%	49.6%	0.0%	0.0%	86.6%
e.	Outpatient STAR Kids Children's Lubbock	46.5%	22.3%	0.0%	0.0%	68.8%
f.	Outpatient STAR Kids Children's Nueces	54.0%	14.6%	0.0%	0.0%	68.6%
g.	Outpatient STAR Kids Children's Tarrant	49.4%	19.3%	0.0%	0.0%	68.6%
h.	Outpatient STAR Kids Children's Travis	36.5%	63.5%	0.0%	0.0%	100.0%
i.	Outpatient STAR Kids Rural Dallas	44.9%	49.8%	0.0%	0.0%	94.7%
j.	Outpatient STAR Kids Rural Jefferson	63.2%	31.5%	0.0%	0.0%	94.7%
k.	Outpatient STAR Kids Rural MRSA West	89.4%	5.4%	0.0%	0.0%	94.8%
l.	Outpatient STAR Kids Rural Tarrant	48.3%	46.3%	0.0%	0.0%	94.6%
m.	Outpatient STAR Kids Rural Travis	74.5%	20.1%	0.0%	0.0%	94.6%
n.	Outpatient STAR Kids State-owned Non-IMD Dallas	29.4%	65.6%	0.0%	0.0%	95.0%
o.	Outpatient STAR Kids State-owned Non-IMD Harris	71.7%	22.9%	0.0%	0.0%	94.7%
p.	Outpatient STAR Kids Urban Bexar	63.7%	35.7%	0.0%	0.0%	99.4%
q.	Outpatient STAR Kids Urban Dallas	27.7%	53.1%	0.0%	0.0%	80.8%
r.	Outpatient STAR Kids Urban El Paso	40.3%	35.1%	0.0%	0.0%	75.4%
s.	Outpatient STAR Kids Urban Harris	88.5%	11.5%	0.0%	0.0%	100.0%
t.	Outpatient STAR Kids Urban Hidalgo	68.8%	19.3%	0.0%	0.0%	88.0%
u.	Outpatient STAR Kids Urban Jefferson	54.2%	17.9%	0.0%	0.0%	72.0%
v.	Outpatient STAR Kids Urban Lubbock	30.9%	43.5%	0.0%	0.0%	74.3%
w.	Outpatient STAR Kids Urban MRSA Central	36.9%	31.8%	0.0%	0.0%	68.7%
x.	Outpatient STAR Kids Urban MRSA Northeast	39.3%	29.4%	0.0%	0.0%	68.7%
y.	Outpatient STAR Kids Urban MRSA West	34.5%	34.2%	0.0%	0.0%	68.7%
z.	Outpatient STAR Kids Urban Nueces	45.4%	34.1%	0.0%	0.0%	79.5%
aa.	Outpatient STAR Kids Urban Tarrant	59.3%	30.3%	0.0%	0.0%	89.6%
bb.	Outpatient STAR Kids Urban Travis	55.7%	39.5%	0.0%	0.0%	95.2%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.14 Inpatient STAR PLUS UHRIP + ACIA + APHRIQA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Inpatient STAR PLUS Children's Bexar	4.4%	95.6%	0.0%	0.0%	100.0%
b.	Inpatient STAR PLUS Children's Dallas	21.4%	78.6%	0.0%	0.0%	100.0%
c.	Inpatient STAR PLUS Children's Harris	18.2%	81.7%	0.0%	0.0%	100.0%
d.	Inpatient STAR PLUS Children's Lubbock	9.9%	83.8%	0.0%	0.0%	93.7%
e.	Inpatient STAR PLUS Children's Nueces	2.7%	92.5%	0.0%	0.0%	95.2%
f.	Inpatient STAR PLUS Children's Tarrant	21.3%	72.4%	0.0%	0.0%	93.7%
g.	Inpatient STAR PLUS Children's Travis	18.2%	75.5%	0.0%	0.0%	93.7%
h.	Inpatient STAR PLUS Rural Bexar	33.9%	61.0%	0.0%	0.0%	94.9%
i.	Inpatient STAR PLUS Rural Dallas	67.4%	27.0%	0.0%	0.0%	94.4%
j.	Inpatient STAR PLUS Rural Hidalgo	40.6%	54.3%	0.0%	0.0%	94.9%
k.	Inpatient STAR PLUS Rural Jefferson	63.4%	36.1%	0.0%	0.0%	99.5%
l.	Inpatient STAR PLUS Rural Lubbock	50.8%	48.8%	0.0%	0.0%	99.6%
m.	Inpatient STAR PLUS Rural MRSA Central	71.1%	23.4%	0.0%	0.0%	94.5%
n.	Inpatient STAR PLUS Rural MRSA Northeast	77.8%	17.0%	0.0%	0.0%	94.9%
o.	Inpatient STAR PLUS Rural Nueces	80.6%	13.7%	0.0%	0.0%	94.2%
p.	Inpatient STAR PLUS Rural Tarrant	83.5%	10.9%	0.0%	0.0%	94.4%
q.	Inpatient STAR PLUS Rural Travis	92.1%	2.8%	0.0%	0.0%	94.9%
r.	Inpatient STAR PLUS State-owned Non-IMD Dallas	29.8%	70.0%	0.0%	0.0%	99.7%
s.	Inpatient STAR PLUS State-owned Non-IMD Harris	54.3%	40.2%	0.0%	0.0%	94.5%
t.	Inpatient STAR PLUS Urban Bexar	27.4%	66.1%	0.0%	0.2%	93.7%
u.	Inpatient STAR PLUS Urban Dallas	21.6%	72.0%	0.0%	0.0%	93.5%
v.	Inpatient STAR PLUS Urban El Paso	17.7%	76.0%	0.0%	0.0%	93.7%
w.	Inpatient STAR PLUS Urban Harris	28.5%	65.2%	0.0%	0.0%	93.7%
x.	Inpatient STAR PLUS Urban Hidalgo	28.4%	65.3%	0.0%	0.0%	93.7%
y.	Inpatient STAR PLUS Urban Jefferson	23.1%	70.6%	0.0%	0.0%	93.7%
z.	Inpatient STAR PLUS Urban Lubbock	15.4%	77.1%	0.0%	1.2%	93.7%
aa.	Inpatient STAR PLUS Urban MRSA Central	32.6%	61.1%	0.0%	0.0%	93.7%
bb.	Inpatient STAR PLUS Urban MRSA Northeast	31.6%	62.1%	0.0%	0.0%	93.7%
cc.	Inpatient STAR PLUS Urban MRSA West	23.4%	70.3%	0.0%	0.0%	93.7%
dd.	Inpatient STAR PLUS Urban Nueces	32.1%	59.4%	0.0%	2.1%	93.7%
ee.	Inpatient STAR PLUS Urban Tarrant	21.1%	72.6%	0.0%	0.0%	93.7%
ff.	Inpatient STAR PLUS Urban Travis	27.5%	66.3%	0.0%	0.0%	93.7%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.15 Inpatient STAR Kids UHRIP + ACIA + APHRIQA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Inpatient STAR Kids Children's Bexar	39.8%	60.2%	0.0%	0.0%	100.0%
b.	Inpatient STAR Kids Children's Dallas	41.7%	58.0%	0.0%	0.0%	99.8%
c.	Inpatient STAR Kids Children's El Paso	29.5%	64.2%	0.0%	0.0%	93.7%
d.	Inpatient STAR Kids Children's Harris	34.0%	65.7%	0.0%	0.0%	99.7%
e.	Inpatient STAR Kids Children's Hidalgo	40.3%	53.4%	0.0%	0.0%	93.7%
f.	Inpatient STAR Kids Children's Lubbock	84.3%	9.4%	0.0%	0.0%	93.7%
g.	Inpatient STAR Kids Children's Nueces	29.3%	65.8%	0.0%	0.0%	95.1%
h.	Inpatient STAR Kids Children's Tarrant	23.9%	69.8%	0.0%	0.0%	93.7%
i.	Inpatient STAR Kids Children's Travis	32.4%	61.3%	0.0%	0.0%	93.7%
j.	Inpatient STAR Kids Non-state-owned IMD Bexar	90.2%	4.5%	0.0%	0.0%	94.7%
k.	Inpatient STAR Kids Non-state-owned IMD Dallas	39.5%	55.3%	0.0%	0.0%	94.8%
l.	Inpatient STAR Kids Non-state-owned IMD Harris	60.5%	34.5%	0.0%	0.0%	95.0%
m.	Inpatient STAR Kids Non-state-owned IMD Hidalgo	91.9%	2.8%	0.0%	0.0%	94.6%
n.	Inpatient STAR Kids Non-state-owned IMD Lubbock	88.8%	10.7%	0.0%	0.0%	99.5%
o.	Inpatient STAR Kids Non-state-owned IMD MRSA West	65.3%	30.7%	0.0%	0.0%	95.9%
p.	Inpatient STAR Kids Non-state-owned IMD Nueces	87.4%	12.2%	0.0%	0.0%	99.6%
q.	Inpatient STAR Kids Non-state-owned IMD Tarrant	88.3%	6.2%	0.0%	0.0%	94.5%
r.	Inpatient STAR Kids Non-state-owned IMD Travis	83.8%	15.9%	0.0%	0.0%	99.7%
s.	Inpatient STAR Kids Rural Hidalgo	75.6%	19.3%	0.0%	0.0%	94.8%
t.	Inpatient STAR Kids Rural Jefferson	9.1%	90.9%	0.0%	0.0%	99.9%
u.	Inpatient STAR Kids Rural MRSA Northeast	41.6%	53.3%	0.0%	0.0%	94.9%
v.	Inpatient STAR Kids Rural Nueces	53.4%	41.1%	0.0%	0.0%	94.6%
w.	Inpatient STAR Kids Rural Tarrant	5.6%	89.3%	0.0%	0.0%	95.0%
x.	Inpatient STAR Kids State-owned IMD El Paso	38.3%	61.3%	0.0%	0.0%	99.7%
y.	Inpatient STAR Kids State-owned IMD Hidalgo	27.5%	67.4%	0.0%	0.0%	94.9%
z.	Inpatient STAR Kids State-owned IMD MRSA West	44.6%	55.3%	0.0%	0.0%	99.9%
aa.	Inpatient STAR Kids State-owned Non-IMD Dallas	33.2%	66.8%	0.0%	0.0%	100.0%
bb.	Inpatient STAR Kids State-owned Non-IMD Harris	70.1%	24.5%	0.0%	0.0%	94.6%
cc.	Inpatient STAR Kids Urban Bexar	33.9%	66.1%	0.0%	0.0%	99.9%
dd.	Inpatient STAR Kids Urban Dallas	19.4%	74.3%	0.0%	0.0%	93.7%
ee.	Inpatient STAR Kids Urban El Paso	20.8%	72.9%	0.0%	0.0%	93.7%
ff.	Inpatient STAR Kids Urban Harris	24.9%	68.8%	0.0%	0.0%	93.7%
gg.	Inpatient STAR Kids Urban Hidalgo	31.7%	68.2%	0.0%	0.0%	100.0%
hh.	Inpatient STAR Kids Urban Jefferson	37.2%	62.5%	0.0%	0.0%	99.7%
ii.	Inpatient STAR Kids Urban Lubbock	24.8%	68.9%	0.0%	0.0%	93.7%
jj.	Inpatient STAR Kids Urban MRSA Central	47.2%	46.5%	0.0%	0.0%	93.7%
kk.	Inpatient STAR Kids Urban MRSA Northeast	26.9%	66.8%	0.0%	0.0%	93.7%
ll.	Inpatient STAR Kids Urban MRSA West	39.8%	53.9%	0.0%	0.0%	93.7%
mm.	Inpatient STAR Kids Urban Nueces	28.3%	65.4%	0.0%	0.0%	93.7%
nn.	Inpatient STAR Kids Urban Tarrant	26.9%	66.8%	0.0%	0.0%	93.7%
oo.	Inpatient STAR Kids Urban Travis	17.4%	76.3%	0.0%	0.0%	93.7%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 2. in the preprint, please delete Tabs 1.A and 3.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 2.A.16 Outpatient STAR UHRIP + ACIA + APHRIQA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Outpatient STAR Children's Bexar	23.6%	70.2%	0.0%	0.0%	93.7%
b.	Outpatient STAR Children's Dallas	80.8%	18.6%	0.0%	0.0%	99.3%
c.	Outpatient STAR Children's El Paso	26.2%	67.5%	0.0%	0.0%	93.7%
d.	Outpatient STAR Children's Harris	53.0%	40.8%	0.0%	0.0%	93.7%
e.	Outpatient STAR Children's Lubbock	26.0%	67.7%	0.0%	0.0%	93.7%
f.	Outpatient STAR Children's Nueces	56.6%	37.1%	0.0%	0.0%	93.7%
g.	Outpatient STAR Children's Tarrant	43.3%	50.4%	0.0%	0.0%	93.7%
h.	Outpatient STAR Children's Travis	29.4%	70.5%	0.0%	0.0%	99.8%
i.	Outpatient STAR Rural Dallas	40.5%	54.3%	0.0%	0.0%	94.8%
j.	Outpatient STAR Rural Jefferson	74.1%	20.7%	0.0%	0.0%	94.8%
k.	Outpatient STAR Rural MRSA Northeast	92.2%	2.7%	0.0%	0.0%	94.9%
l.	Outpatient STAR Rural Tarrant	60.7%	34.0%	0.0%	0.0%	94.6%
m.	Outpatient STAR Rural Travis	58.3%	36.7%	0.0%	0.0%	95.0%
n.	Outpatient STAR State-owned Non-IMD Dallas	25.2%	69.7%	0.0%	0.0%	94.9%
o.	Outpatient STAR State-owned Non-IMD Harris	66.7%	28.0%	0.0%	0.0%	94.7%
p.	Outpatient STAR State-owned Non-IMD MRSA Northeast	64.5%	30.3%	0.0%	0.0%	94.8%
q.	Outpatient STAR Urban Bexar	60.2%	39.7%	0.0%	0.0%	99.9%
r.	Outpatient STAR Urban Dallas	36.3%	57.4%	0.0%	0.0%	93.7%
s.	Outpatient STAR Urban El Paso	42.7%	57.2%	0.0%	0.0%	99.9%
t.	Outpatient STAR Urban Harris	68.2%	31.4%	0.0%	0.0%	99.5%
u.	Outpatient STAR Urban Hidalgo	57.8%	42.2%	0.0%	0.0%	100.0%
v.	Outpatient STAR Urban Jefferson	47.1%	52.7%	0.0%	0.0%	99.8%
w.	Outpatient STAR Urban Lubbock	52.6%	46.9%	0.0%	0.0%	99.5%
x.	Outpatient STAR Urban MRSA Central	38.5%	61.2%	0.0%	0.0%	99.6%
y.	Outpatient STAR Urban MRSA Northeast	35.0%	58.7%	0.0%	0.0%	93.7%
z.	Outpatient STAR Urban MRSA West	37.4%	56.3%	0.0%	0.0%	93.7%
aa.	Outpatient STAR Urban Nueces	48.3%	51.2%	0.0%	0.0%	99.5%
bb.	Outpatient STAR Urban Tarrant	49.7%	50.2%	0.0%	0.0%	99.8%
cc.	Outpatient STAR Urban Travis	41.3%	58.3%	0.0%	0.0%	99.6%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

Directions

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TABLE 2.A.13 Inpatient STAR UHRIP + ACIA + APHRIQA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Inpatient STAR Children's Bexar	49.4%	50.4%	0.0%	0.0%	99.8%
b.	Inpatient STAR Children's Dallas	39.4%	60.3%	0.0%	0.0%	99.7%
c.	Inpatient STAR Children's El Paso	36.5%	57.2%	0.0%	0.0%	93.7%
d.	Inpatient STAR Children's Harris	31.5%	68.4%	0.0%	0.0%	100.0%
e.	Inpatient STAR Children's Hidalgo	34.5%	59.2%	0.0%	0.0%	93.7%
f.	Inpatient STAR Children's Lubbock	40.9%	52.8%	0.0%	0.0%	93.7%
g.	Inpatient STAR Children's Nueces	25.4%	69.7%	0.0%	0.0%	95.1%
h.	Inpatient STAR Children's Tarrant	27.9%	65.8%	0.0%	0.0%	93.7%
i.	Inpatient STAR Children's Travis	27.5%	66.2%	0.0%	0.0%	93.7%
j.	Inpatient STAR Non-state-owned IMD Bexar	68.8%	26.2%	0.0%	0.0%	95.0%
k.	Inpatient STAR Non-state-owned IMD Dallas	56.3%	38.3%	0.0%	0.0%	94.6%
l.	Inpatient STAR Non-state-owned IMD El Paso	78.5%	16.5%	0.0%	0.0%	94.9%
m.	Inpatient STAR Non-state-owned IMD Harris	70.4%	29.6%	0.0%	0.0%	100.0%
n.	Inpatient STAR Non-state-owned IMD Hidalgo	83.7%	10.9%	0.0%	0.0%	94.5%
o.	Inpatient STAR Non-state-owned IMD Lubbock	88.3%	11.5%	0.0%	0.0%	99.7%
p.	Inpatient STAR Non-state-owned IMD MRSA Central	70.7%	29.0%	0.0%	0.0%	99.6%
q.	Inpatient STAR Non-state-owned IMD MRSA West	75.2%	23.3%	0.0%	0.0%	98.6%
r.	Inpatient STAR Non-state-owned IMD Tarrant	67.7%	28.4%	0.0%	0.0%	96.1%
s.	Inpatient STAR Non-state-owned IMD Travis	70.2%	29.5%	0.0%	0.0%	99.7%
t.	Inpatient STAR Rural Bexar	87.0%	12.2%	0.0%	0.0%	99.2%
u.	Inpatient STAR Rural Dallas	51.8%	43.0%	0.0%	0.0%	94.8%
v.	Inpatient STAR Rural Hidalgo	76.7%	18.0%	0.0%	0.0%	94.7%
w.	Inpatient STAR Rural Jefferson	23.9%	76.0%	0.0%	0.0%	99.8%
x.	Inpatient STAR Rural Lubbock	95.5%	3.8%	0.0%	0.0%	99.3%
y.	Inpatient STAR Rural MRSA Central	77.1%	18.5%	0.0%	0.0%	95.6%
z.	Inpatient STAR Rural MRSA Northeast	71.8%	23.0%	0.0%	0.0%	94.8%
aa.	Inpatient STAR Rural Nueces	75.3%	24.1%	0.0%	0.0%	99.4%
bb.	Inpatient STAR Rural Tarrant	39.4%	55.6%	0.0%	0.0%	95.0%
cc.	Inpatient STAR Rural Travis	70.0%	24.5%	0.0%	0.0%	94.5%
dd.	Inpatient STAR State-owned IMD MRSA West	36.6%	63.3%	0.0%	0.0%	99.9%
ee.	Inpatient STAR State-owned Non-IMD Dallas	28.9%	71.0%	0.0%	0.0%	99.9%
ff.	Inpatient STAR State-owned Non-IMD Harris	49.3%	45.4%	0.0%	0.0%	94.7%
gg.	Inpatient STAR Urban Bexar	29.0%	59.6%	0.0%	5.1%	93.7%
hh.	Inpatient STAR Urban Dallas	20.7%	69.8%	0.0%	3.2%	93.7%
ii.	Inpatient STAR Urban El Paso	22.9%	62.5%	0.0%	8.3%	93.7%
jj.	Inpatient STAR Urban Harris	21.3%	76.8%	0.0%	1.8%	99.9%
kk.	Inpatient STAR Urban Hidalgo	25.4%	70.8%	0.0%	0.0%	96.2%
ll.	Inpatient STAR Urban Jefferson	27.8%	68.3%	0.0%	0.0%	96.1%
mm.	Inpatient STAR Urban Lubbock	31.3%	39.8%	0.0%	22.6%	93.7%
nn.	Inpatient STAR Urban MRSA Central	31.5%	62.2%	0.0%	0.0%	93.7%
oo.	Inpatient STAR Urban MRSA Northeast	26.7%	67.0%	0.0%	0.0%	93.7%
pp.	Inpatient STAR Urban MRSA West	27.7%	62.1%	0.0%	4.0%	93.7%
qq.	Inpatient STAR Urban Nueces	29.1%	57.1%	0.0%	7.5%	93.7%
rr.	Inpatient STAR Urban Tarrant	24.8%	68.9%	0.0%	0.0%	93.7%
ss.	Inpatient STAR Urban Travis	33.5%	60.2%	0.0%	0.0%	93.7%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.17 Outpatient STAR PLUS UHRIP + ACIA + APHRIQA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Outpatient STAR PLUS Children's Bexar	18.5%	75.2%	0.0%	0.0%	93.7%
b.	Outpatient STAR PLUS Children's Dallas	88.1%	11.5%	0.0%	0.0%	99.6%
c.	Outpatient STAR PLUS Children's El Paso	44.5%	49.2%	0.0%	0.0%	93.7%
d.	Outpatient STAR PLUS Children's Harris	43.3%	50.4%	0.0%	0.0%	93.7%
e.	Outpatient STAR PLUS Children's Lubbock	19.3%	74.4%	0.0%	0.0%	93.7%
f.	Outpatient STAR PLUS Children's Nueces	52.2%	41.5%	0.0%	0.0%	93.7%
g.	Outpatient STAR PLUS Children's Tarrant	46.3%	47.4%	0.0%	0.0%	93.7%
h.	Outpatient STAR PLUS Children's Travis	16.1%	83.8%	0.0%	0.0%	99.8%
i.	Outpatient STAR PLUS Rural Bexar	76.4%	18.3%	0.0%	0.0%	94.7%
j.	Outpatient STAR PLUS Rural Dallas	64.8%	29.8%	0.0%	0.0%	94.7%
k.	Outpatient STAR PLUS Rural Hidalgo	93.8%	1.0%	0.0%	0.0%	94.8%
l.	Outpatient STAR PLUS Rural Jefferson	78.6%	15.8%	0.0%	0.0%	94.4%
m.	Outpatient STAR PLUS Rural Lubbock	73.3%	26.4%	0.0%	0.0%	99.7%
n.	Outpatient STAR PLUS Rural MRSA Northeast	83.5%	11.5%	0.0%	0.0%	95.0%
o.	Outpatient STAR PLUS Rural MRSA West	78.3%	16.2%	0.0%	0.0%	94.5%
p.	Outpatient STAR PLUS Rural Tarrant	54.0%	40.5%	0.0%	0.0%	94.6%
q.	Outpatient STAR PLUS Rural Travis	58.6%	36.3%	0.0%	0.0%	95.0%
r.	Outpatient STAR PLUS State-owned Non-IMD Dallas	35.7%	58.9%	0.0%	0.0%	94.7%
s.	Outpatient STAR PLUS State-owned Non-IMD Harris	61.9%	32.8%	0.0%	0.0%	94.8%
t.	Outpatient STAR PLUS State-owned Non-IMD MRSA Northeast	52.6%	42.1%	0.0%	0.0%	94.6%
u.	Outpatient STAR PLUS Urban Bexar	58.9%	40.7%	0.0%	0.0%	99.6%
v.	Outpatient STAR PLUS Urban Dallas	33.6%	60.0%	0.0%	0.0%	93.6%
w.	Outpatient STAR PLUS Urban El Paso	65.8%	34.2%	0.0%	0.0%	100.0%
x.	Outpatient STAR PLUS Urban Harris	50.8%	48.8%	0.0%	0.0%	99.7%
y.	Outpatient STAR PLUS Urban Hidalgo	67.6%	32.4%	0.0%	0.0%	100.0%
z.	Outpatient STAR PLUS Urban Jefferson	42.9%	56.7%	0.0%	0.0%	99.6%
aa.	Outpatient STAR PLUS Urban Lubbock	27.4%	66.3%	0.0%	0.0%	93.7%
bb.	Outpatient STAR PLUS Urban MRSA Central	39.4%	60.2%	0.0%	0.0%	99.6%
cc.	Outpatient STAR PLUS Urban MRSA Northeast	50.6%	49.1%	0.0%	0.0%	99.7%
dd.	Outpatient STAR PLUS Urban MRSA West	29.5%	64.2%	0.0%	0.0%	93.7%
ee.	Outpatient STAR PLUS Urban Nueces	69.8%	30.0%	0.0%	0.0%	99.9%
ff.	Outpatient STAR PLUS Urban Tarrant	48.2%	51.6%	0.0%	0.0%	99.8%
gg.	Outpatient STAR PLUS Urban Travis	55.2%	44.7%	0.0%	0.0%	99.9%
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PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

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TABLE 2.A.18 Outpatient STAR Kids UHRIP + ACIA + APHRIQA Payment Levels Compared to ACR UPL

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Outpatient STAR Kids Children's Bexar	18.2%	75.5%	0.0%	0.0%	93.7%
b.	Outpatient STAR Kids Children's Dallas	58.0%	41.8%	0.0%	0.0%	99.8%
c.	Outpatient STAR Kids Children's El Paso	27.3%	66.4%	0.0%	0.0%	93.7%
d.	Outpatient STAR Kids Children's Harris	37.0%	56.7%	0.0%	0.0%	93.7%
e.	Outpatient STAR Kids Children's Lubbock	46.5%	47.2%	0.0%	0.0%	93.7%
f.	Outpatient STAR Kids Children's Nueces	54.0%	39.7%	0.0%	0.0%	93.7%
g.	Outpatient STAR Kids Children's Tarrant	49.4%	44.3%	0.0%	0.0%	93.7%
h.	Outpatient STAR Kids Children's Travis	36.5%	63.5%	0.0%	0.0%	100.0%
i.	Outpatient STAR Kids Rural Dallas	44.9%	49.8%	0.0%	0.0%	94.7%
j.	Outpatient STAR Kids Rural Jefferson	63.2%	31.5%	0.0%	0.0%	94.7%
k.	Outpatient STAR Kids Rural MRSA West	89.4%	5.4%	0.0%	0.0%	94.8%
l.	Outpatient STAR Kids Rural Tarrant	48.3%	46.3%	0.0%	0.0%	94.6%
m.	Outpatient STAR Kids Rural Travis	74.5%	20.1%	0.0%	0.0%	94.6%
n.	Outpatient STAR Kids State-owned Non-IMD Dallas	29.4%	65.6%	0.0%	0.0%	95.0%
o.	Outpatient STAR Kids State-owned Non-IMD Harris	71.7%	22.9%	0.0%	0.0%	94.7%
p.	Outpatient STAR Kids Urban Bexar	63.7%	35.7%	0.0%	0.0%	99.4%
q.	Outpatient STAR Kids Urban Dallas	27.7%	65.9%	0.0%	0.0%	93.6%
r.	Outpatient STAR Kids Urban El Paso	40.3%	53.4%	0.0%	0.0%	93.7%
s.	Outpatient STAR Kids Urban Harris	88.5%	11.5%	0.0%	0.0%	100.0%
t.	Outpatient STAR Kids Urban Hidalgo	68.8%	24.9%	0.0%	0.0%	93.7%
u.	Outpatient STAR Kids Urban Jefferson	54.2%	39.5%	0.0%	0.0%	93.7%
v.	Outpatient STAR Kids Urban Lubbock	30.9%	62.9%	0.0%	0.0%	93.7%
w.	Outpatient STAR Kids Urban MRSA Central	36.9%	56.8%	0.0%	0.0%	93.7%
x.	Outpatient STAR Kids Urban MRSA Northeast	39.3%	54.4%	0.0%	0.0%	93.7%
y.	Outpatient STAR Kids Urban MRSA West	34.5%	59.2%	0.0%	0.0%	93.7%
z.	Outpatient STAR Kids Urban Nueces	45.4%	48.3%	0.0%	0.0%	93.7%
aa.	Outpatient STAR Kids Urban Tarrant	59.3%	34.4%	0.0%	0.0%	93.7%
bb.	Outpatient STAR Kids Urban Travis	55.7%	39.5%	0.0%	0.0%	95.2%
cc.						
dd.						
ee.						
ff.						
gg.						
hh.						
ii.						

PREPRINT SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE
ADDENDUM TABLE 4.A. IGT TRANSFERRING ENTITIES

Directions 4. Use Table 4.A below to add IGT transferring agencies to Table 4. States may also use Table 4.A in lieu of completing Table 4 in the preprint. Provide the following (respond to each column for all entities transferring funds). Input data only in beige cells in columns B - H.

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Note 1 from HHSC: Amounts in the table below are estimated IGT amounts for SFY27.

Column1	Name of Entity transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)	Notes
Data Format	Free text	Set values (select one)	Dollar (\$x,xxx,xxx.00)	Set values (select one)	Free text	Set values (select one)	Free text
i.	ANDREWS COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,934,258.60	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
ii.	ANSON HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$233,963.67	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
iii.	BALLINGER MEMORIAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$345,575.11	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
iv.	BAYLOR COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$517,249.20	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
v.	BELLVILLE HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$904,851.16	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
vi.	BEXAR COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$390,815,702.49	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
vii.	BOSQUE COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$200,225.49	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
viii.	CALHOUN COUNTY	County	\$3,219,056.12	Yes	N/A	Yes	
ix.	CASTRO COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$561,996.06	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
x.	CHILDRESS COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$2,059,274.20	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xi.	CLAY COUNTY	County	\$750,055.36	Yes	N/A	Yes	
xii.	COLEMAN COUNTY MEDICAL CENTER HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$503,813.67	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xiii.	COMANCHE COUNTY CONSOLIDATED HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,191,091.73	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xiv.	CONCHO COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$210,834.65	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xv.	CORYELL COUNTY MEMORIAL HOSPITAL AUTHORITY	Other (specify in "Notes" column)	\$992,787.72	No	N/A	Yes	Hospital Authorities are non-state governmental entities created by a municipality or a county under Chapter 262 or 264, Health and Safety Code. Hospital Authorities do not receive appropriations of state general revenue.
xvi.	COUNTY OF VICTORIA	County	\$38,035,787.45	Yes	N/A	Yes	
xvii.	COUNTY OF WARD	County	\$1,067,187.73	Yes	N/A	Yes	
xviii.	COUNTY OF YOAKUM	County	\$1,449,507.33	Yes	N/A	Yes	
xix.	CRANE COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$457,306.01	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xx.	DALLAM-HARTLEY COUNTIES HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,001,311.46	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxi.	DALLAS COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$963,944,990.87	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxii.	DAWSON COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,701,414.18	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxiii.	DEAF SMITH COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$10,810,290.03	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxiv.	DEWITT MEDICAL DISTRICT	Other (specify in "Notes" column)	\$4,232,904.39	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxv.	DIMMIT REGIONAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$5,803,235.13	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxvi.	EASTLAND MEMORIAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,819,156.94	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxvii.	ECTOR COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$41,217,101.59	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxviii.	EL PASO COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$50,061,706.88	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxix.	ELECTRA HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$678,552.26	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxx.	FAIRFIELD HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$961,154.89	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxxi.	FALLS COUNTY	County	\$1,432,005.90	Yes	N/A	Yes	
xxxii.	FANNIN COUNTY HOSPITAL AUTHORITY	Other (specify in "Notes" column)	\$2,092,511.30	No	N/A	Yes	Hospital Authorities are non-state governmental entities created by a municipality or a county under Chapter 262 or 264, Health and Safety Code. Hospital Authorities do not receive appropriations of state general revenue.
xxxiii.	FISHER COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$364,099.35	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxxiv.	FRIO HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$2,196,041.12	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxxv.	GAINESVILLE HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$4,391,661.19	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxxvi.	GONZALES HEALTHCARE SYSTEMS	Other (specify in "Notes" column)	\$2,790,012.99	Yes	N/A	Yes	Gonzales Healthcare Systems is a hospital district. Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxxvii.	GUADALUPE COUNTY HOSPITAL BOARD	Other (specify in "Notes" column)	\$31,246,943.99	Yes	N/A	Yes	The Board is the governing board of a public hospital. Members of the Board are appointed by the City of Seguin, Guadalupe County, or jointly by the county and the city. The hospital is a unit of local government.
xxxviii.	HAMILTON COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,314,230.96	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xxxix.	HANSFORD COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$383,276.56	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xl.	HARDEMAN COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$762,878.45	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xli.	HARRIS COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$360,884,339.92	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xlii.	HASKELL COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$21,512.17	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xliii.	HUNT MEMORIAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$60,579,706.92	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.

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ADDENDUM TABLE 4.A. IGT TRANSFERRING ENTITIES

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xliv.	HUTCHINSON COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$17,875,700.47	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xlv.	IRAAN GENERAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$143,350.71	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xlvi.	JACK COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,187,188.93	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xlvii.	JACKSON COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$185,233.26	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xlviii.	KARNES COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,233,624.58	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xl ix.	KIMBLE COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$373,247.75	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
l.	KNOX COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$278,395.13	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
li.	LAMB COUNTY	County	\$3,839,732.21	Yes	N/A	Yes	
lii.	LAVACA HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$86,839.84	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
liii.	LIBERTY COUNTY HOSPITAL DISTRICT NO 1	Other (specify in "Notes" column)	\$130,212.89	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
li v.	LOCKNEY GENERAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$928,889.69	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
l iv.	LUBBOCK COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$21,154,964.72	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lvi.	MARTIN COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,451,574.33	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lvii.	MATAGORDA COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$6,957,466.78	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lviii.	MCCULLOCH COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$13,825,401.55	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lix.	MEDINA COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$5,228,096.36	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx.	MIDLAND COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$286,590,807.69	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
l xi.	MITCHELL COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$220,059.61	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxii.	MULESHOE AREA HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$796,141.95	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxiii.	NACOGDOCHES COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$301,146.87	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxiv.	NOCONA GENERAL HOSPITAL	Other (specify in "Notes" column)	\$460,980.69	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx v.	NOLAN COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$2,175,562.45	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxvi.	NORTH RUNNELS HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$125,130.44	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxvii.	NUECES COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$139,331,681.00	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxviii.	OAKBEND MEDICAL CENTER	Other (specify in "Notes" column)	\$55,363,884.38	Yes	N/A	Yes	OakBend Medical Center is a hospital authority created in accordance with Chapter 262, Texas Health and Safety Code. OakBend Medical Center was originally named the Polly Ryon Memorial Hospital and operated under the jurisdiction of the Polly Ryon Hospital Authority. Hospital Authorities are non-state governmental entities created by a municipality or a county under Chapter 262 or 264, Health and Safety Code. Hospital Authorities do not receive appropriations of state general revenue. OakBend Medical Center is considered a local governmental unit under state law. See Oakbend Med. Ctr. v. Martinez, 515 S.W.3d 536.
lx ix.	OCHILTREE COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$632,810.17	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx x.	OLNEY-HAMILTON HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$479,660.30	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx xi.	PALO PINTO COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$2,951,378.82	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx xii.	PECOS COUNTY MEMORIAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$215,880.94	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx xiii.	REEVES COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,026,613.16	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx xiv.	RICE HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$272,347.23	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx x v.	SABINE COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,118,441.81	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx xvi.	SCURRY COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$2,419,851.96	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx xvii.	SEMINOLE HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$2,512,484.49	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx xviii.	STARR COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$1,715,389.05	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx x ix.	STEPHENS MEMORIAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$693,710.30	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx x x.	STONEWALL MEMORIAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$214,279.64	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lx x xi.	SUTTON COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$742,591.17	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.

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Data Format	Free text	Set values (select one)	Dollar (\$x,xxx,xxx.00)	Set values (select one)	Free text	Set values (select one)	Free text
lxxii.	SWEENEY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 2,831,884.05	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxxiii.	SWISHER MEMORIAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 919,970.95	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxxiv.	TARRANT COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 448,630,661.00	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxxv.	TERRY MEMORIAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 4,787,378.06	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxxvi.	THE UNIVERSITY OF TEXAS MEDICAL BRANCH- GALVESTON	Other (specify in "Notes" column)	\$ 363,976,762.84	No	\$ 282,116,943.00	Yes	State University System
lxxvii.	TITUS COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 20,039,320.22	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
lxxviii.	UT HEALTH SCIENCE CENTER AT TYLER	State	\$ 16,441,963.64	No	\$ 53,044,681.00	Yes	State University System
lxxix.	UT SOUTHWESTERN MEDICAL CENTER	State	\$ 293,337,831.03	No	\$ 185,699,102.00	Yes	State University System
xc.	UVALDE COUNTY HOSPITAL AUTHORITY	Other (specify in "Notes" column)	\$ 14,644,778.16	No	N/A	Yes	Hospital Authorities are non-state governmental entities created by a municipality or a county under Chapter 262 or 264, Health and Safety Code. Hospital Authorities do not receive appropriations of state general revenue.
xc.	VAL VERDE COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 14,635,361.81	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xcii.	WALKER COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 2,288,876.58	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xciii.	WEST WHARTON COUNTY HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 3,662,104.41	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xciv.	WILSON COUNTY MEMORIAL HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 5,202,310.43	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xcv.	YOAKUM HOSPITAL DISTRICT	Other (specify in "Notes" column)	\$ 1,229,412.50	Yes	N/A	Yes	Hospital Districts are non-state governmental entities with taxation authority created under the Texas Constitution or by a county as authorized by their applicable Texas statute.
xcvi.	AUSTIN STATE HOSPITAL	State	\$ 3,040,724.73	No	\$ 542,464,655.00	Yes	State general revenue funds are not appropriated to individual state hospitals; therefore, the appropriation amount in column F is the amount appropriated for all state hospitals for FY 23.
xcvii.	EL PASO PSYCHIATRIC CENTER	State	\$ 464,745.82	No	\$ 542,464,655.00	Yes	State general revenue funds are not appropriated to individual state hospitals; therefore, the appropriation amount in column F is the amount appropriated for all state hospitals for FY 23.
xcviii.	NORTH TEXAS STATE HOSPITAL/VERNON	State	\$ 2,972,527.12	No	\$ 542,464,655.00	Yes	State general revenue funds are not appropriated to individual state hospitals; therefore, the appropriation amount in column F is the amount appropriated for all state hospitals for FY 23.
xcix.	NORTH TEXAS STATE HOSPITAL/WICHITA	State	\$ 798,973.90	No	\$ 542,464,655.00	Yes	State general revenue funds are not appropriated to individual state hospitals; therefore, the appropriation amount in column F is the amount appropriated for all state hospitals for FY 23.
c.	RIO GRANDE STATE CENTER	State	\$ 11,890.32	No	\$ 542,464,655.00	Yes	State general revenue funds are not appropriated to individual state hospitals; therefore, the appropriation amount in column F is the amount appropriated for all state hospitals for FY 23.
ci.	SAN ANTONIO STATE HOSPITAL	State	\$ 405,744.74	No	\$ 542,464,655.00	Yes	State general revenue funds are not appropriated to individual state hospitals; therefore, the appropriation amount in column F is the amount appropriated for all state hospitals for FY 23.
cii.	TERRELL STATE HOSPITAL	State	\$ 11,308,020.16	No	\$ 542,464,655.00	Yes	State general revenue funds are not appropriated to individual state hospitals; therefore, the appropriation amount in column F is the amount appropriated for all state hospitals for FY 23.
ciii.							
civ.							
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cvii.							
cviii.							

PREPRINT SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE
ADDENDUM TABLE 5.A. HEALTH CARE-RELATED PROVIDER TAX/ASSESSMENT(S)

5. Use Table 5.A below to add health care-related provider tax/assessments to Table 5 for any SDPs funded by provider taxes/assessments (option c in Question 34). States may also use Table 5.A in lieu of completing Table 5 in the preprint. Provide the following (respond to each column for all entries). Input data only in beige cells in columns B - H. Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide (<https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html>) for how to document SDPs in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.

Directions

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 5 in the preprint, please delete Tabs 1.A - 4.A and 6.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 5.A: Health Care-Related Provider Tax/Assessment(s)

Note 1 from HHSC: Entities are those that participated in FY2025 transfers. This table can be updated if FY2027 entities differ, upon request.
Note 2 from HHSC: Amounts on table 4.A include CHIRP FY2027 transfers from a local governmental entity's (LGE's) general IGT account. Any funds generated through a locally administered health care-related tax (called Local Provider Participation Fund or LPPF) are required to be transferred via IGT from a separate LGE-LPPF account. Please note that because CMS has segregated the tables based on IGT and health care-related taxes, the entities listed here are LGEs that transfer via IGT funds generated from an LPPF.
Note 3 from HHSC: All LPPFs are administered by LGEs; HHSC responses below are based on data collected from LGEs. Column H responses indicate conformity with 42 C.F.R. §433.68(f).

Column1	Name of the Health Care-Related Provider Tax/Assessment (enter each on a separate line)	Identify the permissible class for this tax/assessment	Is the tax/assessment broad-based?	Is the tax/assessment uniform?	Is the tax/assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
Data Format	Free text	Free text	Set values (select one)	Set values (select one)	Set values (select one)	Set values (select one)	Set values (select one)
i.	Angelina County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
ii.	Bell County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
iv.	Bexar County Hospital District	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
v.	Bowie County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
vi.	Brazos County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
vii.	Cameron County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
viii.	City of Amarillo Hospital District	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
ix.	Collin County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
x.	County of Ellis	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xi.	Dallas County Hospital District	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xii.	El Paso County Hospital District	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xiii.	Grayson County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xiv.	Gregg County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xv.	Harris County Hospital District	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xvi.	Hays County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xvii.	Hidalgo County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xviii.	Jefferson County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xix.	Lubbock County Hospital District	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xx.	McLennan County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xxi.	Northeast Health Care Provider Participation (HCPP) District	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xxii.	Nueces County Hospital District	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xxiii.	Smith County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xxiv.	Tarrant County Hospital District	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xxv.	Taylor County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xxvi.	Tom Green County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xxvii.	Webb County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xviii.	Wichita County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xxix.	Williamson County	Inpatient Hospital Services	Yes	Yes	Yes	N/A	No
xxx.							
xxxi.							
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xxxvi.							
xxxvii.							

PREPRINT SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS
ADDENDUM TABLE 7.A. PAYMENT ARRANGEMENT QUALITY STRATEGY GOALS AND OBJECTIVES

Directions 7. Use Table 7.A below to add any goal(s) and objective(s) this payment arrangement is expected to advance as they appear in the state Quality Strategy (include page numbers). States may also use Table 7.A in lieu of completing Table 7 in the preprint. Input data only in beige cells in the three columns.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 7 in the preprint, please delete Tabs 1.A - 6.A and 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 7.A: Payment Arrangement Quality Strategy Goals and Objectives

Column1	Goal(s)	Objective(s)	Quality strategy page #
Data Format	Free text	Free text	Free text
Example:	Improve care coordination for enrollees with behavioral health conditions	Increase the number of managed care patients receiving follow-up behavior health counseling by 15%	pp. 20-22
a.	Promote optimal health through prevention and by engaging people, families, communities, and the health care system to optimize health outcomes.	Increase screening for chronic disease, behavioral health conditions, and substance use disorders	p. 3
b.	Keep patients free from harm by building a safer healthcare system.	Address non-medical drivers of health Reduce avoidable complications or adverse health care events in all care settings Reduce severe maternal morbidity Reduce unnecessary cesarean sections Reduce avoidable hospital readmissions	p. 3
c.	Promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs.	Improve the treatment and management of chronic physical health condition or serious illness Improve the treatment and management of behavioral health conditions and substance use disorders, prioritizing services in community settings Strengthen person-centered practices and family engagement in care	p. 4
d.	Use high quality health information for people, families, communities, and the health care system to make data driven decisions to improve quality health care for all Texans.	Expand health information exchange (HIE) capacity and participation in the state with particular focus on Medicaid, public health, and behavioral health services	p. 4
f.			
g.			
h.			
i.			
j.			
k.			