TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

December 8, 2014

Mr. Tim Hill
Director, Financial Management Group
Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21224-1850

RE: Deferral # TX/2014/3/E/03/MAP

Dear Mr. Hill:

We appreciate the opportunity to speak on Monday and we appreciate CMS lifting the deferral of Uncompensated Care (UC) payments. We are sending this letter to begin the next phase of discussions concerning the funding of UC and Delivery System Reform Incentive Payments (DSRIP) in Texas. Through this letter, we hope that CMS will better understand HHSC's position on the issues presented in the deferral.

CMS' deferral letter dated September 30, 2014 expressed concerns that intergovernmental transfers (IGTs) from public entities for use as the non-federal share of payments to private hospitals "may be derived from funds that the government entity previously would have spent on providing the services that are now being provided/funded by the private entity and or direct payments made to the governmental entity from private entities." CMS indicated that it wanted to further explore its understanding of the funding mechanisms used and of the intersection of those mechanisms with the guidance contained in State Medicaid Director Letter (SMD) #14-004.

Since receiving the September 30, 2014 letter, HHSC executive management, legal and program staff have taken the following steps:

- Met with Cindy Mann, you, your staff and others at CMS to gain a better understanding of your concerns about Texas' approach to funding UC and DSRIP payments to private hospitals;

- Provided CMS' Regional Office with information and documents responsive to that office's request for documents;

- Reviewed the documents that were provided to us by Jeoffrey Branch, the CMS Financial Management Review team lead, which, according to Mr. Branch, are the basis of findings that led to the deferral;

- Reviewed correspondence and documentation related to the creation of the private hospital UPL program in 2005 and 2006;

- Reviewed correspondence and documentation submitted to CMS in 2007 and 2008 in relation to the deferral and subsequent release of funds associated with the Private Hospital Upper Payment Limit program; and,

- Worked closely with representatives of the participating private hospitals that are the subject of the deferral to gain a deeper understanding of the relationships that are being questioned by CMS.

This process has led HHSC to conclude there is no evidence of donations from private hospitals to the governmental entities that fund the non-federal share of UC and DSRIP payments. The private hospitals are neither assuming a fiscal or programmatic obligation of a local government nor making a direct payment to a local government. CMS' suspicion that local governmental entities would not provide IGT "but for" a provider-related donation is unsupported by evidence.

I. The Questioned Models Do Not Establish A Donation or an Impermissible Donation

CMS has not identified specific evidence of a non-bona fide donation from any of the private hospitals for which payments were deferred. CMS apparently believes the funding models themselves establish the existence of a donation, possibly in reliance on the guidance and examples in the May 9, 2014, SMD letter. In this section of the letter, HHSC will show the relationships in Dallas, Tarrant and Nueces Counties do not result in a donation at all under federal regulations.

There is no single model of funding relationship in the four regions of the state that were the subject of CMS' Financial Management Review. Within the reviewed regions, there appear to be three different types of funding relationships that are described in the documentation relied upon by CMS; within the regions that had payments deferred, there are at least two.[1] In other regions of the state, there are scenarios that are different from any of those in the regions reviewed by CMS. In this letter, HHSC will focus on the relationships that are the subject of the deferral.[2]

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[1] In its notification of deferral dated September 30, 2014, CMS deferred claims related to hospitals in three regions and indicated that federal matching funds might be at risk for a fourth -- the "Austin" region. CMS has not subsequently notified HHSC of a deferral associated with expenditures in that region.

[2] Given the variety of public-private partnerships in Texas, HHSC believes that an analysis of whether a funding partnership results in an impermissible provider-related donation should be made on a case-by-case basis supported by facts and evidence unique to that partnership. HHSC and Texas stakeholders will continue to provide CMS with information necessary to evaluate these partnerships.

A. Partnering to Provide Indigent Care Is Not A Donation

The documents relied upon by CMS to defer payments to private hospitals in Dallas and Tarrant County and to some hospitals in Nueces County are contractual and financial documents of non-profit organizations supported by the private hospitals that received the waiver payments in question. The private hospitals are members of or otherwise support the following non-profit organizations: the Dallas County Indigent Care Corporation (DCICC); the Tarrant County Indigent Care Corporation (TCICC); and Texas Bay Area Clinical Services, Inc. (TBACS).[3] The private hospitals have also entered into indigent care affiliation agreements with their public partners to work collaboratively to improve access to health care for indigent persons.

The Dallas County model was the subject of scrutiny by CMS in 2007 and 2008 during a deferral of Texas' Private Hospital Upper Payment Limit (UPL) program. HHSC and Texas stakeholders provided CMS with thousands of pages of documents concerning the Dallas County model and conducted multiple conference calls and meetings with CMS to discuss that model. After extensive consideration by CMS, and certain revisions to the underlying agreements, CMS lifted the deferral. CMS's review and subsequent lifting of the deferral with full knowledge of how the program worked constituted at least tacit approval that the Dallas County model complied with federal law.[4] The Tarrant County Indigent Care Affiliation Agreement was first effective in May 2009 and the arrangement was structured consistent with the Dallas County model.

1. CMS' Historical Approval of the Dallas County Model is Consistent With Federal Law

CMS correctly interpreted federal law to permit the Dallas County model to be used in Texas from the resolution of the Private Hospital UPL deferral until now because there is no donation from the private hospital to the public entity. Federal law defines a provider-related donation as: (1) a donation or other voluntary payment (whether in cash or in kind); (2) made (directly or indirectly) to a state or unit of local government; (3) by a health care provider or related entity.[5]

Under this model, there is no donation to a *governmental* entity. The private hospitals are providing a benefit to *individuals* who receive charity care or other community services; there is no payment in cash or in kind to the unit of local government.

Nor are the private hospitals assuming any legal obligation of the governmental entity. CMS, in the preamble to its 2007 cost rules (ultimately vacated for other reasons), recognized that the pivotal issue in assessing compliance with provider donation regulations was whether a private hospital provides services that are the *legal obligation* of a governmental entity.[6] In 2008, Texas

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[3] The three hospitals in Nueces County that provide charity care through the TBACS are DeTar Healthcare System, Corpus Christi Medical Center, and Driscoll Children's Hospital.

[4] The history of this deferral is discussed extensively in the October 31, 2014, Letter from Kay Ghahremani to Cindy Mann.

[5] 42 U.S.C. § 1396b(w)(2)(A) (2014); 42 C.F.R.§ 433.52 (2014).

[6] *Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership*, 72 Fed. Reg. 29748, 29762-99 (May 29, 2007) (stating "[l]ocal government tax dollars that are not contractually committed for the purpose of indigent care services or any other non-Medicaid activity can be directly

and CMS agreed the existence of a government legal obligation should be the deciding factor in determining whether a provider donation occurred, and CMS lifted the Private Hospital UPL deferral. Without the certainty of a legal obligation to define when a donation occurs, what remains is a murky area that is impossible to define, audit or enforce fairly. It is therefore necessary to distinguish between legal obligations and historical practices of local governmental entities in order for CMS's rules to be enforceable.[7]

The past practice of a governmental entity electing to pay for certain services does not create a legal obligation for the governmental entity to continue to do so in the future. It is not clear whether CMS intentionally has adopted a new position and, if so, what the legal basis for this new position is, but the only way to characterize the Dallas County model as resulting in a provider donation is if the prior provision of care by the public entity creates an ongoing legal obligation for the government to continue to provide these services in perpetuity. When private entities provide services in the community at their sole discretion, some of which may have previously been provided by a governmental entity, there is no donation. The mere expectations and historical practices of the private and the governmental entities do not somehow transform the provision of care to patients into a provider donation.

2. The Dallas County Arrangement Has Not Changed Since 2008

The Dallas County arrangement has not changed in any significant way from the one described in documents submitted to CMS in 2007. One of the documents provided to CMS was a memorandum describing the Dallas County model, a copy of which is attached to this letter as Exhibit 1.[8] Another document submitted to CMS in 2008 was a letter explaining why there is no assumption of obligations of the local governmental entity. That letter is attached as Exhibit 2. These documents (along with many others provided to CMS in 2007-2008) explain why these longstanding relationships do not result in a donation to the governmental entity.

The Tarrant County arrangement and TBACS were not in existence at the time of the Private Hospital UPL program deferral, but are structured consistent with the Dallas County model. A letter to HHSC from the hospitals that are members of the TBACS is attached to this letter as Exhibit 3 and contains a comprehensive explanation of the non-profit entity and why its funding arrangement is like those approved by CMS when the UPL deferral was lifted.

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transferred by the local government to a state as the non-Federal share of Medicaid payments" and explaining a provider donation would result if a private hospital provides services "which were otherwise State only or local government only, obligations often involving health care services to a non-Medicaid individual.").

7 *See, e.g., Grayned v. City of Rockford*, 408 U.S. 104 (1972) ("if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who enforce them.").

8 The attachments referenced in the memorandum are not included here because of their volume, but will be provided upon request.

3. The May 9, 2014, SMD Letter is Ambiguous But May Be Read To Support Texas' Models

At first glance, the May 9, 2014, SMD letter appears to reflect a reversal of CMS' longstanding position that the Dallas model does not, in and of itself, establish the existence of a donation so long as the governmental entity has no continuing legal obligation to provide such care. The letter contains a description of a public-private partnership that CMS would consider non-bona fide in which a local governmental entity terminated its existing contract with a service provider; a private hospital executed "the same contract" with the service provider; and the governmental entity used the savings to support a supplemental payment to the private hospital. This fact situation is similar to what occurred in the Dallas area in Private Hospital UPL in 2007, after which CMS – with full knowledge of the facts – allowed the private hospitals to participate in UPL and the waiver program for the next seven years. Although it may be inadvertent, this example in the May 9, 2014, SMD letter is troubling because it suggests that CMS has reversed its previous interpretation of what constitutes a provider donation under federal law.

The SMD letter states that government entities are free to enter into agreements with private entities, but Medicaid payments may be in jeopardy if a hold harmless provision or practice exists. The letter then summarizes the federal regulation describing situations in which a hold-harmless practice exists:

> A hold harmless practice exists if there is a positive correlation between the agreement and the Medicaid payments, Medicaid payments are conditioned upon the receipt of a donation from a private entity, or if there is a guarantee that the private entity will see a return of some, or all, of that donation through a Medicaid payment.[9]

In the federal regulation, however, the analysis of a hold harmless practice becomes relevant only if a provider donation exists, to determine whether the donation is bona fide or impermissible.[10] What appears to be missing from the example in the SMD letter is the identification of the provider donation. The Dallas model does not result in a donation at all, and therefore the hold-harmless analysis consequently should not be triggered.

Even so, to HHSC's knowledge, there is no evidence in the documents relied upon by CMS of agreements that contain a hold-harmless provision. Furthermore, to the extent any agreements exist between private hospitals and governmental entities, all private hospitals and governmental entities certify the absence of a relationship in those agreements that would represent a hold harmless relationship (no conditioning of Medicaid payments on non-Medicaid services or vice versa).[11]

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[9] SMDL #14-004 at page 1. This differs from the reference to "positive correlation" in federal regulation, which relates only to a non-Medicaid payment.

[10] 42 C.F.R. §433.54(b)-(c).

[11] Waiver Program Certification of Hospital Participation, § 2(c); Certification of Governmental Entity Participation for Hospital Affiliates, § 4; 42 C.F.R. § 433.54(c) (2014).

There is also no evidence that CMS has shared with HHSC:

- Of a positive correlation between the indigent care affiliation agreement and Medicaid or non-Medicaid payments received by a private hospital;

- That a private hospital's Medicaid payments are conditioned upon the receipt of a donation to the public entity or upon the provision by or payment for provider services; or

- That a private hospital or non-profit entity is guaranteed to see a return of some or all of its costs of providing services or funding services.

HHSC believes the May 9, 2014, SMD letter can fairly be read to allow the Dallas County model used in many areas of Texas, while cautioning states and stakeholders that they must carefully adhere to federal law in structuring their public-private partnerships so that (1) the payment for services to indigent populations by private entities is not done pursuant to an agreement guaranteeing a return of funds to the private entity; and (2) the IGT by a governmental entity is not conditioned on the provision of or payment for indigent or other services by the private entities.

4. If CMS Intends the May 9, 2014, SMD Letter To Change Its Interpretation of Federal Law, Notice Is Required

If CMS intends the May 9, 2014, SMD letter to change its longstanding interpretation of federal law, it should engage in notice and comment rulemaking before enforcing the new interpretation against states and stakeholders through a deferral or disallowance.

A case currently under appeal before the U.S. Supreme Court is very similar to the current situation in which HHSC finds itself with CMS. In *Bankers Ass'n v. Harris, Sec'y of Dept. of Labor* [now Perez],[12] the Mortgage Bankers Association ("MBA") filed suit against the U.S. Department of Labor ("DOL") for issuing a 2010 opinion letter that overturned a previous 2006 opinion letter relating to the Fair Labor Standards Act ("FLSA"). The 2006 opinion letter provided that loan officers are to be considered exempt employees under the FLSA and are therefore not entitled to overtime pay, whereas the 2010 opinion letter found otherwise. The DOL did not provide notice or opportunity to comment on the 2010 opinion.

The D.C. Court of Appeals that heard the MBA case ruled that since the 2010 opinion letter had the same effect as a rule and that this significant change constituted a repeal or amendment, the DOL should have provided notice and opportunity to comment.

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12 720 F.3d 966 (D. C. Cir. 2013).

> If the Department of Labor ("DOL") wishes to readopt the later-in-time interpretation, it is free to. We take no position on the merits of their interpretation. DOL must, however, conduct the required notice and comment rulemaking.[13]

In its ruling, the D.C. Court of Appeals noted that its decision was consistent with its longstanding prior rulings, and that changes in agency interpretations have the same effect as a change in rules that require notice and comment under the APA.

> When an agency has given its regulation a definitive interpretation, and later significantly revises that interpretation, the agency has in effect amended its rule, something it may not accomplish [under the APA] without notice and comment.[14]

Previously, the Fifth Circuit Court of Appeals came to a similar conclusion in *Shell Offshore Inc. v. Babbitt, et al.*[15] In *Shell*, the court found that a "significant departure from long established and consistent practice that substantially affects the regulated industry" obliges a federal agency "to submit the change for notice and comment."[16] As such, in this case, the U.S. Department of Interior violated the APA by issuing an opinion letter overturning longstanding policy.

Regulated parties "are entitled to know the rules by which the game will be played" and have a right to participate and offer potentially beneficial insight in the rulemaking that will govern their actions.[17] Therefore, if CMS intends to use the May 9, 2014 SMD letter as its new interpretation of federal law, CMS must give providers an opportunity for notice and comment.

B. The CHRISTUS Spohn Arrangement Does Not Create a Donation

The document upon which CMS apparently relied to defer funding associated with hospitals operated by CHRISTUS Health System is the Spohn Membership Agreement. To date, CMS has not explained what terms of the agreement it believes establish the existence of a donation. However, Mr. Branch stated to HHSC staff that CMS is questioning the fact that the Nueces County Hospital District receives more patient revenue under the agreement than it did under a lease agreement in effect prior to the date of the Spohn Membership Agreement.

The increased revenue that accrues to Nueces County Hospital District (NCHD) under the membership agreement is not a donation from a private entity; it is public funding that belongs to NCHD as a co-member of the non-profit corporation that operates the safety-net hospital. As

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13 *Id.* at 968.
14 *See, e.g., Alaska Prof'l Hunters Ass'n v. Fed. Aviation Admin.*, 177 F.3d 1030, 1034 (D.C. Cir. 1997); *Paralyzed Veterans of America v. D.C. Arena L.P.*, 117 F.3d 579, 326 U.S. App. D.C. 25 (D.C. Cir. 1997).
15 238 F.3d 622 (5th Cir. 2001).
16 *Id.* at 630.
17 *Alaska Prof'l Hunters Ass'n,* 177 F.3d at 1035-36 (*citations omitted*).

explained in the Overview of 2012 Spohn Membership Agreement that is attached as Exhibit 4 to this letter, the hospital district shares the rights, privileges, obligations and duties attendant to being a co-member of the organization. Pursuant to the agreement, NCHD shares the financial risks of being a co-member, as well as the financial benefits, if any. Not only were the corporate documents revised to reflect NCHD as a co-member, but the parties submitted the appropriate enrollment change documents to the Medicare fiscal intermediary and the State related to its Medicare and Medicaid provider agreements. As explained in Exhibit 4, the membership agreement:

> [W]as negotiated at arm's length in the ordinary course of business among the parties for bona fide and commercially reasonable business reasons unrelated to the Waiver and continued the evolution of the collaborative relationship between the District and Spohn that began in 1996.[18]

In other words, this public-private agreement is exactly the type of business transaction between a governmental entity and a private entity that, according to the May 9, 2014, SMD letter, is a valid way for a state to provide Medicaid services and with which CMS will not interfere.

II. Conclusion

HHSC is not aware of – and CMS has not identified – any evidence of a donation from a private hospital in the Dallas, Tarrant or Nueces County areas to a governmental entity that funded the non-federal share of UC payments to the hospital. CMS seems to suggest the public-private partnership models alone establish the existence of a donation. HHSC believes neither Federal law nor regulations support such a finding.

When private hospitals are parties to indigent care affiliation agreements that result in expanded charity care and other community benefits, there is no donation because there is no payment in cash or in kind from the private entity to the governmental entity. CMS reviewed these exact relationships in 2008 and correctly interpreted federal law to permit their continuation for over seven years. CMS should continue to allow public and private entities to work together in ways that have the result of expanding care to indigent populations or providing other healthcare-related benefits in the community, as long as those agreements do not contain any provider-related donations in violation of federal law. Under the Spohn Membership Agreement, there is no donation because the agreement is an arm's length transaction entered into for commercially reasonable business reasons unrelated to Medicaid payments.

We recognize the Texas waiver program is complicated in some respects, especially regarding the participation of private hospitals in the waiver program. The agreements and transactions that make up public-private partnerships differ in each local community, although safeguards put in place by HHSC in 2008 are applicable to all of the entities that receive waiver funding. HHSC understands that some of these transactions raise issues that CMS is obliged to investigate.

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[18] Exhibit 4 at page 8.

However, having reviewed the documents and spoken with representatives of the entities reviewed by CMS, HHSC has concluded that all of the payments subject to the deferral are proper and compliant with federal law. We hope that this letter persuades CMS to come to the same conclusion and we are ready to work with CMS to provide any additional documentation or explanations necessary to reach that end. Please let us know what else we can provide, if anything, to address CMS' concerns so that the 1115 Waiver can continue succeeding for the people of the State of Texas.

Sincerely,

Kay Ghahremani
HHSC State Medicaid Director

EXHIBIT 1

MEMORANDUM

August 21, 2007

To: James C. Frizzera, Center for Medicaid and State Operations
Daniel Aibel, Department of Health and Human Services, Office of General Counsel

From: Thomas Dowdell, Fulbright & Jaworski LLP (Counsel for Baylor Health Care System)
Holley Thames Lutz, Sonnenschein Nath & Rosenthal LLP (Counsel for HCA)
Fred Carroll, Senior Attorney, Texas Health Resources
Mickey Price, Chief Legal Officer, Methodist Health System
Charles Luband, Powell Goldstein LLP (Counsel for the Dallas County Hospital District)
Gary Eiland, Vinson & Elkins LLP (Counsel for the University of Texas Southwestern Medical Center at Dallas)

Cc: Kevin Nolting, Texas Health and Human Services Commission

Re: Dallas County (Texas) Indigent Care Affiliation

The purpose of this memorandum is to provide background and additional information regarding the attached documents, which reflect the current Dallas County model for implementing an affiliation under Texas's regional upper payment limit program (the "Dallas Model"), which is authorized by Texas State Plan Amendment (TX-05-011). We discussed the prior implementation with you in person on May 4, 2007 and via conference call on June 5, 2007. Again, we greatly appreciate your willingness to discuss these issues with us and to provide feedback. The current implementation is substantially revised to address issues raised during our conversations.

As discussed previously, the Dallas Model involves certain private hospitals in Dallas County, known as the Affiliated Hospitals, the Dallas County Hospital District, d/b/a Parkland Health & Hospital System (the "District"), and also the University of Texas Southwestern Medical Center at Dallas ("UT Southwestern"), whose physicians have traditionally provided services to indigent patients at the District's hospital.

We previously provided you with the following documents regarding the prior implementation:

- The Dallas County Indigent Care Affiliation Agreement and accompanying certifications by the Affiliated Hospitals and the District;
- An Assignment of Master Services Agreement between the District and the Affiliated Hospitals;
- A Management Agreement between the District and the Affiliated Hospitals; and
- A Memorandum of Agreement between UT Southwestern and the Affiliated Hospitals.

Of these documents, only the Dallas County Indigent Care Affiliation Agreement currently survives, and that document has been amended. More specifically, the changes to the agreements noted above are as follows. First, the original Dallas County Indigent Care Affiliation Agreement has undergone minor amendments. (The Affiliation Agreement and amendments are attached as Exhibit A. The certifications have not changed and are not included.) Second, the Assignment of

Master Services Agreement between the District and the Affiliated Hospitals has been terminated as of March 30. Third, the underlying Master Services Agreement between the District and UT Southwestern has also been terminated, with two minor exceptions. That is, the District and UT Southwestern will continue their initial agreement solely as it pertains to (i) specified physician services that are funded by grants to the District, and therefore must be purchased by the District using the grant funds, and (ii) the billing arrangements for certain nurse midwives employed directly by the District. Fourth, the Management Agreement between the District and the Affiliated Hospitals has also been terminated as of March 30. Fifth, an Administrative Services Agreement was created between UT Southwestern and the Affiliated Hospitals as contemplated by the Memorandum of Agreement, but it expired March 30. In order to reduce the amount of materials submitted, we have not attached the contractual documents related to these actions, except the Administrative Services Agreement, as these documents do not relate to the current implementation of the Dallas Model. Of course, we are happy to share any and all of these documents with you.

The current implementation of the Dallas Model, effective March 31, 2007, involves the same parties as the prior implementation, plus the addition of the Dallas County Indigent Care Corporation ("DCICC"). DCICC is a new membership non-profit corporation created by the Affiliated Hospitals to provide or arrange for health care for the indigent population of Dallas County. The Affiliated Hospitals are the only members of DCICC and are solely responsible for the governance of DCICC. Again, in order to reduce the amount of materials submitted, we have not attached organizational documents related to DCICC (e.g., by-laws, articles of incorporation), although we are happy to share them if desired. DCICC was created on July 3, 2007.

The key components of the current implementation of the Dallas Model are as follows:

- First, there is a new Master Services Agreement between the Affiliated Hospitals and UT Southwestern effective March 31, 2007, for the provision of services by UT Southwestern to indigent patients of the District on behalf of the Affiliated Hospitals. (This is attached as Exhibit B.)

- Second, a Quality Assurance Agreement exists between the Affiliated Hospitals and the District, effective March 31, 2007 setting out requirements necessary to assure legal compliance and the continued quality of care provided at the District's facilities. (This is attached at Exhibit C). As of August 10, 2007, both of these agreements are assigned from the Affiliated Hospitals to DCICC, through the Assignment of Master Services Agreement and Quality Assurance Agreement. (This is attached as Exhibit D.)

- Third, DCICC has entered into an arm's length Consulting Agreement with the District effective August 10, 2007, in order to facilitate the delivery of quality care to inpatients and outpatients at the District's facilities. (This is attached as Exhibit E.)

- Fourth, given that DCICC is a new corporation with no financial history, the Affiliated Hospitals agreed to provide assurances to UT Southwestern that DCICC will fulfill its payment obligations. (The Guaranty and Acknowledgement for each Affiliated Hospital is attached as Exhibit F.)

The current Dallas Model does not include sharing Medicaid revenue among the Affiliated Hospitals during the existence of the Dallas Model. Although, respectfully, we do not concede that such a provision creates a legal issue, we understand CMS has raised concerns about this issue and we note that the Dallas Model does not include this feature. In addition, the funding of indigent care has

been modified so that the Affiliated Hospitals do not fund their indigent care obligations based on their proportion of supplemental payments. Rather, two Affiliated Hospitals each fund one-third of the indigent care obligation and two Affiliated Hospitals each fund one-sixth of the obligation.

There are additional documents (also attached) addressing the contingency of a negative determination related to the Dallas Model:

(1) The Affiliated Hospitals have entered into a Mutual Indemnity Agreement to assure the responsibilities of each hospital if there is an adverse determination as to the Dallas Model, i.e., a recoupment, or if one hospital fails to make a required payment under the Master Services Agreement. (This is attached as Exhibit G.)

(2) The District and UT Southwestern have entered into a Memorandum of Agreement which dictates what would happen if the new Master Services Agreement were to terminate or expire, otherwise leaving the District without physician services for the patients at its facilities. This is necessary because otherwise, there is no contractual obligation existing for these services by and between UT Southwestern and the District. (This is attached as Exhibit H.)

(3) Although the term of the Administrative Services Agreement expired March 30, 2007, we have attached this document as well, because this document was not available when we last provided documents to you and addresses contingencies related to recoupment of Medicaid payments paid for periods prior to March 31, 2007. (This is attached as Exhibit I.)

We would greatly appreciate any confirmation, feedback, clarification, and/or guidance that you can provide. We will contact you in the near future to discuss a follow-up meeting. Please let us know if you have follow-up questions. Finally, thank you for your time and attention.

List of Exhibits

Exhibit A	Dallas County Indigent Care Affiliation Agreement and Amendments
Exhibit B	Master Services Agreement between the Affiliated Hospitals and UT Southwestern
Exhibit C	Quality Assurance Agreement between the Affiliated Hospitals and the District
Exhibit D	Assignment of Master Services Agreement and Quality Assurance Agreement from the Affiliated Hospitals to DCICC
Exhibit E	Consulting Agreement between DCICC and the District
Exhibit F	Guaranty and Acknowledgement by each Affiliated Hospital
Exhibit G	Dallas County Indigent Care Affiliated Hospitals Mutual Indemnity Agreement among Affiliated Hospitals
Exhibit H	Memorandum of Agreement Relating to Partial Termination of Master Services Agreement between the District and UT Southwestern
Exhibit I	Administrative Services Agreement between the Affiliated Hospitals and UT Southwestern

EXHIBIT 2

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

February 4, 2008

Via Federal Express

Bill Brooks
Acting Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
1301 Young Street, Room 833
Dallas, Texas 75202

Re: Deferral # TX/2007/3/E/12/MAP

Dear Mr. Brooks:

This letter responds to the Regional Office letter of October 5, 2007, which notified the Texas Health and Human Services Commission (HHSC or "the Commission") of the decision of the Centers for Medicare & Medicaid Services (CMS) to defer claims made by Texas's Medicaid program for $72,633,689 in federal financial participation (FFP) in the April and June 2007 quarters. The claims were made in connection with the State's private hospital upper payment limit (UPL) program. The letter expressed two concerns raised by an ongoing CMS Financial Management Review (FMR):

(1) "Private hospitals may be satisfying certain fiscal obligations that are otherwise those of local governments," thereby creating non-bona-fide provider-related donations; and

(2) "[A] portion of the Medicaid payments made under the private hospital UPL program are re-directed by the hospitals to satisfy certain non-Medicaid activities," in violation of Section 1902(a)(30)(A) of the Social Security Act ("Act").

The letter included a list of information and documents needed by the Regional Office.

Since receiving the letter, we have provided to you all of the information and documents that we received from the entities participating in the private hospital UPL program responsive to your

request for documents. We have also spoken with representatives of the participating private hospitals that received April and June 2007 UPL payments.

Our inquiries lead us to conclude that the $72,633,689 deferral should be withdrawn. We believe that the private hospitals neither satisfied fiscal obligations of the local governments nor impermissibly redirected funds. This letter summarizes the bases for our conclusion.

I. Introduction

The private hospital UPL program in Texas is built on the premise that private hospitals may provide charity care to indigent patients in a way that relieves local government entities from incurring expenses for such care that they might otherwise incur (without relieving local government entities of any actual obligations they might have under State law or under contracts). The local government entities, thus relieved, are able to contribute toward the support of Medicaid providers in their communities. This arrangement, as well as the manner in which it was implemented at the community level, is consistent with State and federal law and with the purpose of the Medicaid program. The program is driven by expectations but not by binding requirements on any participant, and it neither depends upon provider-related donations nor induces improper redirection of Medicaid funds.

II. The private hospitals did not assume obligations of the local government entities.

In correspondence with CMS regarding the State plan amendments (SPAs) that created the private hospital UPL program, the State explained the premise of the program as follows:

- Local government entities "joined with private safety-net hospitals to design a collaborative program to more fully fund the Medicaid program under current law and ensure the availability of quality healthcare services for the indigent population."[1]

- These collaborations each involved an indigent care agreement, that is, an agreement between the local government entity and a group of local private hospitals "to develop a plan for the Affiliated Hospitals to alleviate the Local Taxing Entity's tax burden by providing care to the indigent, thereby allowing the Local Taxing Entity to utilize its ad valorem tax revenue to fund the Medicaid program."[2]

- "The provision of these indigent services by the Affiliated Hospitals directly to indigent patients will alleviate a portion of the Local Taxing Entity's expense of providing indigent care. The Local Taxing Entity will utilize part of its ad valorem

[1] Letter from David J. Balland to Andrew A. Frederickson, at 4 (June 30, 2006).

[2] *Id.*

> tax revenue dedicated to healthcare needs to fund the Medicaid program," which it would do either by making an intergovernmental transfer (IGT) of the tax revenue to the State or by making a supplemental payment directly to the affiliated hospitals.[3]

The State understood CMS's approval of the SPAs to entail acceptance of this basic justification for the program. That acceptance was not misplaced. As we explain in more detail below, the private hospitals' provision of charity care to indigent patients did not relieve the local government entities of any obligations under Texas law or contracts, and did not constitute provider-related donations.

A. There was no assumption of obligations under Texas law.

Under Texas law, hospital districts and counties are generally required to provide or pay for indigent care, but only as payors of last resort and *not* where other sources of payment for care are available. The scope of the local government entity's obligation is not to provide or pay for all indigent care, but rather, only to provide or pay for indigent care that someone else is not providing or paying for. *See generally* Tex. Health & Safety Code § 61.022(b) ("The county is the payor of last resort and shall provide assistance only if other adequate public or private sources of payment are not available."); *id.* § 61.060(c) ("A public hospital is the payor of last resort under this subchapter and is not liable for payment or assistance to an eligible resident in the hospital's service area if any other public or private source of payment is available.").[4]

Texas employs a somewhat unique concept of what it means to provide indigent care. Local government entities are considered to have provided indigent care whether they directly provide care to patients or instead pay for someone else to do so. *See, e.g.*, *id.* at § 61.029(a) ("A county may arrange to provide health care services through a local health department, a publicly owned facility, or a contract with a private provider regardless of the provider's location, or through the purchase of insurance for eligible residents.").

This same notion of the provision of indigent care extends to the charity care concept under Texas law. Charity care is provided by private hospitals and is defined as "the unreimbursed cost to a hospital of":

> (A) providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as "financially indigent" or "medically indigent"; and/or

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[3] *Id.* at 4-5.

[4] These provisions are part of the Indigent Health Care and Treatment Act of 1985, enacted pursuant to Article IX, Section 9A, of the Texas Constitution, also adopted in 1985 to enable the Texas legislature to define the scope of hospital districts' responsibilities for indigent care. The statute also covers those responsibilities of counties.

> (B) providing, funding, or otherwise financially supporting health care services provided to financially indigent persons through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

Id. § 311.031(2). These provisions establish two basic models for providing charity care:

> (1) directly providing inpatient and outpatient services to the financially indigent (as determined by the hospital) in the private hospital setting; and
>
> (2) supplying the financing for health care services provided through other entities (such as nonprofit or public health care organizations).

The provision of charity care is a benefit to the patient. It is not, however, a benefit to a county or hospital district that might otherwise have paid for such care had it not been provided as charity care, or that formerly paid for such care, because when care is voluntarily provided by a private hospital as charity care to a financially indigent patient, neither the county nor the hospital district is obligated to pay for such care. That is so both because the local government entity has no obligation to pay where the private hospital (or anyone else) is paying for the service as charity care, and because the private hospital's decision to provide care as charity care to a financially indigent person means it can never later decide to seek payment from any source. *See id.* at § 311.031(7) ("'Financially indigent' means an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility system.").

In short, providing charity care does not relieve an obligation of the hospital district or county. Rather, it is a voluntary undertaking by a private hospital that benefits the patient.[5]

B. Basic models of providing charity care to indigents

The private hospitals participating in the UPL program provide charity care within two basic models that correlated with the basic methods of providing charity care under Texas law.[6] The first model (the "county model") corresponds to the first basic type of charity care described above: a private hospital's direct provision of inpatient and outpatient hospital services to the indigent within its own facility.

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[5] In some cases, providing charity care may be an obligation of certain private hospitals. *See* Tex. Health & Safety Code § 311.043(a) ("A nonprofit hospital shall provide health care services to the community . . . . These health care services to the community shall include charity care and government-sponsored indigent health care . . . .").

[6] This description is based primarily on the documents and representations provided by the law firm of Gjerset & Lorenz, LLP, which represented the private hospitals in most of the communities that participated in the private hospital UPL program during the deferral period. We understand that the other communities employed models similar to the ones described in the text.

The county model was used in counties lacking their own public hospital facilities. In these counties, the county traditionally offered indigent healthcare services at private hospitals, by paying these private hospitals to provide the services. Historically, these private hospitals provided some charity care (that is, care granted to a patient without completing eligibility paperwork for a county indigent care or other reimbursement program, so that the services were irrevocably deemed to be charity care for which the hospital could no longer attempt to bill or collect) and some care to patients who appeared to be potentially eligible for Medicaid or other sources of third-party payment (for which the hospital would secure the requisite paperwork and proceed to bill the appropriate payor). Among the sources of third-party payment that the hospitals sometimes billed was the county indigent care program, which generally paid for indigent care on a fee-for-service model.

Under the county model, the private hospitals decided to grant charity care of the type just described more often. The hospitals chose to classify hospital services provided to the indigent as charity care (for which no bill could be submitted) when they formerly would have billed the county (for reimbursement under the county's indigent care program). As a consequence, the county is no longer paying for claims from the private hospitals for indigent care. This result, in turn, frees up money, which the county is able to set aside and ultimately transfer as the IGT that forms the non-federal share of UPL payments to the private hospitals.

The second model (the "district model") corresponds to the second basic type of charity care described above: funding charity care through a nonprofit or public healthcare organization. The district model was typically used in hospital districts, often (though not always) with their own hospital facilities. The local government entity in these communities historically had contracts with physician groups and other vendors of healthcare services to serve indigent patients.

Generally, these contracts provided for monthly, reimbursement to the vendors. Under the district model, these contracts were terminated, after which the private hospitals, generally through a nonprofit healthcare organization, entered into new contracts with the providers, pursuant to which the private hospitals funded the provision of charity healthcare for indigents. With the money no longer being spent under the terminated contracts, the district was able to make an IGT to fund increased Medicaid payments.

Two common features of both models are worth noting. The first is that both models entail a significant increase in the amount of charity care burden borne by private hospitals within each community. The increase in private charity care is valuable both as an end in itself, and as the factor that enabled counties to generate greater financial support for the Medicaid providers in their area.

The second key feature is that the indigent care program overall, and the models used to implement it, did not impose binding commitments on the local government entities or on the private hospitals. Rather, it created a set of aspirational goals – increased provision of charity care to alleviate the tax burden on the local government entity, and increased support for the Medicaid program – that were promoted through a set of incentives for present trust and future cooperation, as opposed to any threat of legal enforcement against any party. Thus, local

government entities were not legally obliged to fund IGTs at all or any particular amount, and in some cases, they did not fund IGTs in the full amount that the private hospitals might have expected.

By a similar token, private hospitals were not legally obliged to provide any set amount of charity care, and the amount of charity care they provided did not affect whether they received a UPL payment or the amount of UPL payment they received from HHSC. The UPL payments to each hospital related only to the Medicaid services provided by each hospital, as provided in the regulations implementing the SPAs.

We understand that with respect to the issue of binding commitments, CMS has some concerns regarding the Needs Analyses employed in each community. We have been informed that many communities decided during the summer and fall of 2007 not to renew their Needs Analyses. We also believe, however, that the Needs Analyses serve important and legitimate purposes, and that communities should be able to implement (or re-implement) them going forward.

C. There was no assumption of contractual obligations.

The models implementing the private hospital UPL program did not relieve local government entities of any contractual obligations, just as they did not relieve local government entities of any State law obligations. To the extent the local government entities had preexisting contractual obligations to third parties, such as physician groups, those obligations were terminated.

In some cases, termination was accomplished by means of an actual cancellation of the local government entity's contract with the third party, followed by the creation of a new contract between that third party and a nonprofit or public healthcare organization established by the affiliated private hospitals. In other cases, termination was accomplished by means of the local government entity's assignment of its role under the preexisting contract to the private hospitals or nonprofit or public healthcare organization, with the consent of the third party. The legal effect of this was to extinguish the local government entity's contractual obligation.[7]

There is no difference, either in fact or in law, between assignment-plus-consent and cancellation in this context. After the local government entity assigned the contractual obligations it owed to the third party, and after the third party consented to that assignment – thereby discharging the local government entity from all contractual obligations that might otherwise remain – the local

[7] *See Honeycutt v. Billingsley*, 992 S.W.2d 570, 576 (Tex. App. 1999) (stating that "[a] novation is the substitution of a new agreement between the same parties or the substitution of a new party on an existing agreement," and that "only the new obligation may be enforced"); *Savitch v. Southwestern Bell Yellow Pages, Inc.*, 2005 Tex. App. LEXIS 6215, at *10 (Tex. App. 2005) ("Novation is the creation of a new obligation in the place of an old one, by which the parties agree that a new obligor will be substituted to perform the duties agreed upon by the old contract, while the original obligor is released from performing those duties.").

government entity had no remaining contractual obligation toward the third party. *See Honeycutt*, 992 S.W.2d at 576; *Savitch*, 2005 Tex. App. LEXIS 6215, at *10. The effect on the local government entity is exactly the same as though it and the third party had agreed to cancel their contract, and the third party had entered into a new contract with the private hospitals or their non-profit corporation.

Representatives of the private hospitals have further informed us that where the private hospitals undertook to pay for physician and other non-hospital professional services that were provided at governmentally operated facilities, those physician services were not provided by employees of the facilities. The funding, in other words, did not go toward the salaries of the physician-employees of the governmentally operated hospitals, but rather toward the payment of contracted physicians and other non-hospital professional services.

D. There were no other transactions related to the UPL payments covered by the deferral designed to benefit the local government entities.

A memorandum dated November 8, 2007, from Billy Bob Farrell to Kevin Nolting, raises a question whether there had been "[c]ompensation" to local government entities through "affiliated hospitals[']purchase [of] items for the local government (i.e. purchase of capital equipment or assumption of local government contractual obligations)," which might have amounted to "another form of a non-bona fide provider-related donation to the local governments by the private hospitals." Memorandum from Billy Bob Farrell to Kevin Nolting [hereinafter "Farrell Memorandum"], ¶ 2 (Nov. 8, 2007). A copy of the Farrell Memorandum is attached to this letter.

We have explained above why provision of charity care was not an assumption of local government obligations. With respect to the concern that private hospitals might have purchased equipment for local government entities, or provided anything else of value to local government entities, we have diligently searched for and inquired about any such transactions and, with one possible exception[8], we have found none that related in any way to the payments in April and June 2007 that are the subjects of the deferral. Representatives of the private hospitals receiving those payments have advised us that they were scrupulous in advising their clients not to engage in such transactions, and they have stated categorically that as far as they are aware, no such transactions actually occurred.

With respect to later payments, in August 2007, there were apparently some transactions between certain affiliated hospitals and the county hospital in at least one instance that entailed making equipment available. We are continuing to investigate this instance, and any other similar transaction that may have related to the August 2007 payments. We will report the results of those inquiries in our response to the letter deferring the claim that covers the August 2007 payments.

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[8] We are continuing to investigate this arrangement and will provide more information to you within a few days..

III. There Was No Impermissible Redirection of Funds.

The deferral letter states that preliminary documentation indicates that some portion of the payments made under the private UPL program "are re-directed by the hospitals to satisfy certain non-Medicaid activities," and states that such a "re-direction of Medicaid payments" is inconsistent with Section 1902(a)(30)(A) of the Act.

In our investigation we have discovered no transactions or arrangements that would constitute "re-direction of Medicaid payments" in connection with the April and June 2007 UPL payments that would be inconsistent with the Act. The deferral letter does not state what is meant by "re-direction" and the term is not used in the statutory provision cited nor in any other provision of the Act or regulations. However, from our discussions we understand CMS to be using the term to describe the type of payment plan involved in *Alaska Department of Health & Social Services*, DAB No. 2103 (2007), where the Departmental Appeals Board agreed with CMS that FFP could not be provided for payments made to hospitals subject to the condition that the hospitals expend 90% of the amounts received to pay providers of non-Medicaid services.

The models underlying the private UPL payments involve no such "re-direction" of Medicaid payments. There are no requirements of any kind for how the hospitals use the SPA payments. In particular:

- The private hospitals are not required to, and do not, pass any amount of money back to the State or local government entities. Participating entities are required to sign certifications stating that there is no such return of UPL payments, and our investigation has revealed no circumstance in which such payments were made.

- The private hospitals are not required to spend any funds on charity care (UPL payments or otherwise) as a condition of receiving the UPL payments. Hospitals have voluntarily increased their provision of charity care, but as we have shown, this does not satisfy any obligation of state or local governmental entities.

- There are no required transfers of funds by the hospitals to anyone else (including each other). Certain hospitals have agreed among themselves to make certain payments to each other. No law requires these transfers, and they do not result in any funds coming back either to the State or to the local government entities.

The increase in the amount of charity care provided by private hospitals (either directly or through a nonprofit or public healthcare organization funding others) does not constitute impermissible "redirection" of Medicaid funds. CMS has long recognized that providers are free to use funds received in payment for services to Medicaid recipients as they choose, and are not

limited to using them to cover the costs of serving Medicaid patients. *See Alaska Dept. of Health & Soc. Services*, DAB No. 2103, at 24.[9] Whatever the limits of the "redirection" policy may turn out to be, they would not embrace the use of a hospital's own funds to expand its charity care commitment, as long as that expansion is not mandated by the State or any other governmental body.

IV. Other issues

While the foregoing addresses the stated grounds for the deferrals, we would like to address the other issues raised in the Farrell Memorandum. The bullet-points below correspond to the numbered paragraphs in the Farrell Memorandum.

- ¶1: Recoupment of funds: this issue is addressed in the response to Deferral # TX/2007/3/E/11/MAP.

- ¶ 2: Compensation by provision of local government "needs": this issue is addressed above, in Part II.D of this letter.

- ¶ 3: Management or administration fees: this paragraph states that "[l]ocal governments are being paid a management or administration fee to manage the local indigent care programs," that "[t]hese fees are usually based on a percentage of the private hospital UPL program payments," and that these arrangements constitute "a redirection of the Medicaid payment."

  We do not believe that this description is accurate. While there were instances in which local government entities did receive payments for providing support or administrative services in connection with the care provided by the affiliated hospitals, representatives of the private hospitals have represented to us that their management or administrative fees were not tied to UPL payments, but were instead fair payment for services rendered to the affiliated hospitals, and in any event amounted only to a small fraction of the UPL supplements paid to the hospitals. We are also informed that the management and administration agreements are now being phased out in favor of "in-house" management and administration by the private hospitals (or the nonprofit organizations).

- ¶ 4: Contingency fees to consultants: this paragraph states that "[c]onsultants are contracted with affiliated private hospitals to receive up to 3.5%

[9] Embedded in the concept of prospective payment, the method used to reimburse hospital services in the Medicare program and most state Medicaid programs, is the ability of the hospital to receive payments that are greater than its costs. To the extent it does so, the provider is free to use the excess for any legitimate purpose it elects.

contingency fees for legal and consulting services relative to the private UPL program," and that such fees are "a redirection of the Medicaid payment."

We are not aware of any such contingency fee agreements. Counsel familiar with most of the arrangements have represented that contingency fees were not paid to their firm. In any event, there is no legal prohibition against contingency fees. As stated above, notwithstanding the "redirection" or "retention" principle (however it is labeled), hospitals are entitled to spend Medicaid payments as they wish, provided they do not

(a) spend Medicaid money on non-Medicaid purposes because the State or local government requires them to, or

(b) spend Medicaid money – or indeed, any money – on making non-bona-fide donations to the State or local government.

Neither concern is implicated in a fee agreement that exists purely between, and according to the terms set by, a private hospital and its consultant.

- ¶ 5: Escrow representative agreements and district representative agreements: this paragraph states that some of these agreements "include compensation for those representatives (banking, consultants, or local government entities), usually on a percentage or contingency basis," thus creating "a redirection of the Medicaid payment."

  We are informed by the representatives of the private hospitals that there were no payments to the escrow representatives or district representatives; these individuals simply told the escrow agents (*i.e.*, the banks) how much money the district wished to transfer as an IGT. We are told that the banks acting as escrow agents charged customary fees that were imposed on an annual or per transaction basis, and others were based on a nominal percentage of the escrow account balance. (In these cases the escrow enabled the local government entities to set aside and preserve funds for the IGTs.)

- ¶ 6: Transferring of FFP after payment: this paragraph states that "private hospitals in the affiliated group are transferring a portion of their UPL payments to other private hospitals in the affiliated group," "sometimes due to the private hospitals in the group compensating the publics for actual indigent care," and sometimes "to fund the State share of the UPL payments for other hospitals in the affiliated group in exchange for a repayment of the transfer plus a percentage of the benefiting hospital's UPL payment."

  We have addressed above the transfers between private hospitals, but wish to reemphasize that the transfers were voluntary – that is, they were not a "redirection of the Medicaid payment," because they were not required by the

State or local government entity. Moreover, the transfers were not donations – that is, they did not go to the local government entity in order to fund the IGTs, but rather were purely between or among the private hospitals.

- ¶ 7: Calculating payments based on unallowable service charges: this paragraph states that "hospitals were instructed to include charges for outpatient, physician, private lab and radiology ('throw everything in there'), in the calculation of the costs for private UPL payments."

  The UPL supplemental payments were determined in relation to the recipient hospitals' share of the Medicare-based UPL, not costs or charges. We are unaware of any case in which a hospital was paid more than it was entitled to either under the SPAs or under other applicable federal limitations, but if such a case comes to light, we will correct that hospital's UPL payment.

- ¶ 8: No changes in the provision of Medicaid or indigent care: this paragraph states that "[p]rivate hospitals are receiving Medicaid supplemental funding but do not actually provide or expand Medicaid or indigent care under the program," and that although "[m]ost of the contractual documents require a commitment by the private hospitals to 'provide indigent care,'" "[w]hat actually happens is that the public/safety net hospitals . . . are still providing the same levels of Medicaid and indigent care as they were prior to the program, and the private hospitals are merely funding the public hospitals."

  The UPL payments are not for indigent care or for an increase in indigent care. The UPL payments are supplements to Medicaid payments for hospital services. The validity of the UPL program does not turn on whether there has been an increase in indigent care or Medicaid services provided. The payments strengthen important sources of Medicaid coverage, and are warranted on that basis alone.

  In any event, as explained above, there has been a significant increase in charity care provided by the private hospitals. The private hospitals planned to, and did, increase the charity care they provided to indigents, by way of the two basic methods that Texas law recognizes for the provision of charity care (direct hospital care to indigents within the private hospitals' facilities, and funding such care through a nonprofit organization).

- ¶ 9: Using alternative funds for IGTs: this paragraph states that "[s]ome local governmental entities are obtaining loans or letters of credit to fund the IGT's rather than using their own tax dollars," in violation of "federal guidelines and the Texas State Plan," which "require the use of ad valorem tax dollars for [IGTs]."

We are unaware of the specific communities to which this paragraph refers. In any event, a local government that borrows money to fund an IGT is still funding that IGT with ad valorem tax dollars, because the loan will eventually have to be repaid, and it will be repaid with ad valorem tax dollars. The true funding source is not the lender's money (which is only temporary, and is ultimately returned), but the local government's. Government entities frequently utilize borrowing as a cash management tool, when confronted with substantial outlays that do not align in time with receipts from taxes.

- ¶ 10: Some of the private affiliates are not hospitals: this paragraph states that "[s]ome private entities receiving hospital UPL payments under this program are not hospitals, but free standing surgical or psychiatric treatment centers, and in one case, an office housing administration operations only," that "[t]hese facilities are owned by national corporations," that "[h]ospital UPL is not available to these entities," and that "this procedure is outside of the state plan provisions."

  The SPAs require the recipients to be hospitals. A hospital that is otherwise eligible to receive UPL payments is not rendered ineligible simply because (a) it is owned by a national corporation or (b) it asks that payments be directed to its administrative office or one of its components. As for whether any individual hospital for which "hospital UPL is not available" received a payment, we are unaware of any instance where this occurred. To the extent CMS views this as a concern, we would need more information from CMS about the specific cases thought to be improper.

The Texas private hospital UPL program is complicated in some respects. It operates within a unique body of State law and it is implemented somewhat differently in each local community, in part by a set of agreements and transactions that are facially rather daunting. We understand that as a result, the program may appear to raise some issues that CMS is obliged to investigate. We also appreciate CMS's willingness to provide us with the time necessary to gather the information for our response, and to share with us the memorandum shedding additional light on issues connected with the deferral. Having reviewed the documents and spoken with representatives of the participating entities, we have concluded that the payments subject to the deferral were proper and compliant with the State plan. We hope that this letter persuades you to come to the same conclusion, but if it does not, please let us know what other information we can provide.

If you have any questions, please contact Kevin Nolting at 512-491-1348 or by e-mail at Kevin.Nolting@hhsc.state.tx.us.

Sincerely,

Chris Traylor

Chris Traylor
Associate Commissioner for Medicaid and CHIP

Enclosures

cc: Albert Hawkins, Executive Commissioner
Charles Bell, Executive Deputy Commissioner for Health Services
Tom Suehs, Executive Deputy Commissioner for Financial Affairs

EXHIBIT 3

November 20, 2014

Ms. Kay Ghahremani
State Medicaid Director
Texas Health and Human Services Commission
Mail Code: H100
P.O. Box 13247
Austin, Texas 78711

Re: Texas Bay Area Clinical Services

Dear Ms. Ghahremani:

We are writing in response to the recent letter from the Centers for Medicare and Medicaid Services ("CMS") to the Texas Health and Human Services Commission ("HHSC") dated September 30, 2014, deferring approximately $74.9 million in Federal Financial Participation for Medicaid Supplemental Payments made to private hospitals (the "Deferral"). This letter is a response from three of the private safety-net hospitals in the Coastal Bend Region [RHP4] whose payments are subject to the Deferral: DeTar Healthcare System ("DeTar"), Corpus Christi Medical Center, and Driscoll Children's Hospital (the "Affiliated Hospitals"). Based on the Deferral, CMS appears to be concerned with the possible existence of prohibited provider-related donations in the context of the Affiliated Hospitals' relationship with its local governmental entity ("GE"), the Nueces County Hospital District (the "District").

The Affiliated Hospitals, through a non-profit health organization called Texas Bay Area Clinical Services, Inc. ("TBACS"), expanded the delivery of care to the needy, low-income and uninsured patients (collectively referred to as "low-income patients") in their region. TBACS makes payments directly to the providers of low-income care. Neither TBACS nor the Affiliated Hospitals have given anything of value, either through a donation or any other voluntary payment, to the District or any other GE. The expanded delivery of health care services to the low-income has been to serve the growing population of the needy in the community; it was not an in-kind transfer of value, directly or indirectly, or "provider-related donation" to the District to further the District's purposes. The definition of a "provider-related donation" includes "a donation or other voluntary payment … ***to a State or unit of local government***."[1] Because there is no value given to the District, there is no provider-related donation by the Affiliated Hospitals. In fact, the Affiliated Hospitals engage in exactly the same activity that CMS thoroughly reviewed and approved in 2007-2008 in response to a similar deferral in the context of the Texas

[1] 42 C.F.R. § 433.52.

private hospital Medicaid supplemental payment program, and the Affiliated Hospitals comply with all the restrictions and safeguards that CMS and HHSC put in place at that time.

This letter clarifies the nature of the low-income care services provided by the Affiliated Hospitals and explains why these services do not violate federal provider-related donation law. We hope that this will help HHSC clarify any misunderstandings and promote openness and transparency in the process.

THE AFFILIATED HOSPITALS AND TEXAS BAY AREA CLINICAL SERVICES

The Affiliated Hospitals are an essential part of the safety-net health care system in the Coastal Bend Region (which includes Nueces County) and have for a long time been providing low-income care in their communities. The Affiliated Hospitals routinely partner in the community on various health care initiatives.

Driscoll Children's Hospital is a non-profit, tax exempt children's hospital formed over 60 years ago for the sole purpose of providing low-income care. As part of its larger mission, Driscoll Children's Hospital and its affiliates participate in community needs assessments, local health fairs and numerous community-based educational programs, including television and radio programming on relevant public health issues. Driscoll serves patients in 31 counties and 33,000 square miles of South Texas and operates clinics throughout South Texas. As such, Driscoll customarily collaborates with health care providers in neighboring counties. For instance, a Driscoll-owned affiliate has partnered with the Victoria Regional Health Alliance (of which DeTar is a participant) to conduct community-wide educational baby showers through the Cadena de Madres program. Additionally, Driscoll and DeTar have maintained a voluntary patient transfer agreement for many years. Driscoll also operates a pediatric medicine residency program in affiliation with Texas A&M University.

DeTar is a for-profit acute care hospital that provides healthcare services to residents of Victoria and surrounding counties, including inpatient and outpatient services, health-centered educational opportunities, and a variety of community services. DeTar Healthcare System has two hospitals in Victoria, Texas. One is a general acute care facility, and the other is predominantly Women's and Children's focused, but it also has a psychiatric inpatient program for geriatric patients. DeTar serves eight counties in South Texas. DeTar provides a significant amount of uncompensated care to residents of Victoria and surrounding counties and participates in a number of community outreach efforts. DeTar's pre-natal clinic covers several counties and DeTar works intensively with local community organizations, such as WIC or pregnancy crisis centers, in an effort to improve delivery outcomes.

Corpus Christi Medical Center is a for-profit acute care hospital originally formed over 50 years ago and is now comprised of multiple campuses that delivers a wide range of health care services, including, without limitation, 24-hour emergency care, orthopedic services, inpatient and outpatient medical/surgical care, cardiology and cardiovascular services, newborn services, oncology services and psychiatric services. Corpus Christi Medical Center has provided a significant amount of uncompensated care to the residents of the Nueces County. Over the

years, Corpus Christi Medical Center has participated in health fairs, provided free health screenings (such as diabetes screenings and healthy heart screenings), and has volunteered staff and physicians for local radio and television health and wellness programs. Corpus Christi Medical Center has offered support groups to the community, such as for stroke and weight loss. Like Driscoll Children's Hospital, Corpus Christi Medical Center also participates in community-based education programs. Corpus Christi Medical Center has also maintained a voluntary patient transfer agreement with Driscoll Children's Hospital for many years. Additionally, Corpus Christi Medical Center has operated family practice and internal medicine residency programs for several years and continues to do so today. In short, all of the Affiliated Hospitals have a long tradition of working separately and together to provide free and discounted care to low-income residents in the region. As explained below, the Texas Healthcare Transformation and Quality Improvement Program (the "Waiver") has benefited the region by acting as a catalyst to deepen those relationships.

Under the special terms and conditions of the Waiver approved by CMS, and in compliance with HHSC's rules, private hospitals are required to enter an Affiliation Agreement with a GE to receive uncompensated care ("UC") payments.[2] The Affiliation Agreement does not require the Affiliated Hospitals to provide any specific service to qualify for UC payments. The Affiliated Hospitals may agree among themselves to provide additional low-income care in the community and the District may acknowledge these efforts when determining whether to support UC payments through intergovernmental transfers ("IGTs"). The District, however, retains full and sole discretion whether or not to make IGTs, and the Affiliated Hospitals retain full and sole discretion whether or not to provide low-income care. In other words, receipt of Medicaid funds is not contingent on the Affiliated Hospitals' providing low-income care, and the Affiliated Hospitals' provision of low-income care is not contingent on receipt of Medicaid funds. Here, the District has made no promises, assurances or guarantees of IGT, express or implied, to any of the Affiliated Hospitals.

As part of their effort to expand charitable health care in the community and as a means to best utilize their joint resources, in 2012 the Affiliated Hospitals formed TBACS, a Texas non-profit health organization certified by the Texas Medical Board. TBACS's three members are affiliates of the Affiliated Hospitals: (1) Community Health Physicians Operation Holding Corporation, LLC, an affiliate of DeTar; (2) Bay Area Healthcare Group, Ltd., the owner and operator of Corpus Christi Medical Center; and (3) Children's Physician Services of South Texas, of which Driscoll Children's Hospital is the sole member. TBACS enables the Affiliated Hospitals to deliver low-income care by contracting with independent providers, to jointly share in the liability for the care delivered and to centralize the administrative functions necessary to deliver that care.[3]

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[2] Waiver Special Terms and Conditions, ¶ 44(a)(i)(C)(I) ("Private providers must have an executed indigent care affiliation agreement on file with HHSC"); 1 T.A.C. § 355.8201(c)(1)(B)

[3] While TBACS was being formed, the Affiliated Hospitals used an existing non-profit health organization certified by the Texas Medical Board, Montgomery County Clinical Services, Inc. ("MCCS"), which is an affiliate of Bay Area Healthcare Group, Ltd. to begin expeditiously providing care to the community. MCCS entered into the contracts with the independent providers and these contracts were automatically assigned to TBACS upon its certification from the Texas Medical Board (through an automatic assignment provision contained in the contracts).

To date, TBACS has provided services through over 50 contracts with independent providers for low-income care in the Coastal Bend. By utilizing the District facilities, TBACS is able to deliver cost-effective care without having to expend additional dollars or capital for physical facilities and duplicative physician coverage; instead, those dollars are spent paying the providers to furnish health care services to low-income patients in their community. The payments are made to the physicians or their groups; no payments are made to the District.

The low-income care services furnished by the Affiliated Hospitals through TBACS bestow a direct benefit on the patients who receive the health care services and do not alleviate the District of any constitutional, statutory, or contractual obligation to provide the services.

THE PROVISION OF LOW-INCOME CARE SERVICES IS NOT A DONATION TO THE DISTRICT

CMS appears concerned that the Affiliated Hospitals' expansion of low-income care services could be a non-bona fide provider-related donation. In the Deferral, CMS states that "[i]t appears that the intergovernmental transfer (IGT) may be derived from funds that the government entity previously would have spent on providing the services that are now being provided/funded by the private entity and or direct payments made to the government entity from private entities." Since there are "no direct payments made to the government entity from private entities," we assume CMS's focus with respect to the Affiliated Hospitals is whether the District is using funds that it "would have spent on providing the services now being provided/funded by the private entity."

Under federal law and regulations, a provider-related donation is a voluntary contribution, in cash or in kind, made directly or indirectly, to a state or unit of government by a provider or related entity.[4] The expansion of low-income care by Affiliated Hospitals is not a provider-related donation under this definition because the Affiliated Hospitals do not give *anything* of value to the District (or any other GE). This fundamental fact is evidenced by the following:

(1) All of the services provided by the Affiliated Hospitals are for patient care. The funds used for low-income care are for services the patients directly receive. The Affiliated Hospitals do not engage in any services that may provide a direct benefit to the District, even incidentally, such as the donation of physical assets for use by the District or the improvement of any governmental assets.

(2) The Affiliated Hospitals deliver patient care through TBACS, a non-profit health organization that is certified by the Texas Medical Board to practice medicine; no cash or in kind, direct or indirect, payments are made to the District.

(3) The District does not receive any revenue associated with the care that TBACS delivers.

[4] 42 U.S.C. § 1396b(w)(2)(A); 42 C.F.R. § 433.52.

Neither the District nor the Affiliated Hospitals direct or control the way in which the other entity chooses to support low-income care in the Coastal Bend. The Affiliated Hospitals have no way of knowing the source of the funding that the District uses as an IGT, nor do they have any input into the way that the District would have spent the funds if it did not make the IGT. Further, the expansion of low-income care by the Affiliated Hospitals does not alleviate the District of any legal obligation. Specifically, in 2007, CMS expressed the position that an indirect provider-related donation occurs when a private provider:

(1) Forgoes a legal right to payment "…to which it is contractually entitled from a local government"[5]; or
(2) Takes over legal obligations "which were otherwise state only or local government only obligations often involving health care services to non-Medicaid individuals."[6]

Under Texas law, hospital districts are generally required to provide or pay for indigent care, but only as payors of last resort and *not* where other sources of payments are available.[7] Therefore, as hospitals increase their provision of low-income care, local hospital districts have more funds to spend on other services, and may use funds to support supplemental Medicaid payments to private hospitals. This basic interconnection between public and private sector providers has existed in Texas since before the Waiver and even before the Medicaid supplemental payment program.

The issue of what represents a provider-related donation was extensively briefed following CMS's deferral of Texas Private Hospital UPL payments in 2007.[8] Our understanding is that following the 2007 Deferral, CMS and HHSC agreed that expansions of low-income care did not implicate provider-related donation restrictions and lifted the Deferral. Subsequently, HHSC requested that private hospitals sign Certifications of Hospital Participation ("CHPs") affirming, among other things, that they have not conditioned the amount of low-income care they provide on the amount of funds transferred by a GE or the amount of Medicaid supplemental funding they expect to receive (or vice versa) and that they have not "consented to the assumption of a statutory or contractual obligation of the [GE]".[9] These certifications have been used for seven (7) years under the UPL and Waiver programs to guard against prohibited provider-related donations. The Affiliated Hospitals are in compliance with all of the CHPs.

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[5] Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748, 29762 (May 29, 2007) (although this regulation was later abrogated for violations of the federal Administrative Procedural Act, we understand that the language expressed in the *Federal Register* still represents logical guidance from CMS as to the definition of a provider-related donation) ("2007 Regulations").

[6] *Id.* at 29799.

[7] Tex. Health and Safety Code Ann. § 61.060 (stating "public hospital is the payor of last resort under this subchapter and is not liable for payment or assistance to an eligible resident in the hospital's service area if any other public or private sources of payment are available.")

[8] *See*, February 4, 2008 letter from Albert Hawkins, Executive Commissioner of HHSC, to Bill Brooks, Acting Associate Regional Administrator of CMS, Re Deferral #TX/2007/3/E/12/MAP.

[9] Private Hospital Certification, § 2(d).

In summary, CMS appears to base the Deferral on conclusions not supported by the facts or the law surrounding provider-related donations. In particular, the provision of low-income care services by the Affiliated Hospitals is not a prohibited provider-related donation because it is not a donation or other voluntary payment to the District or any other GE; rather, it is the delivery of services directly to the patients. Further, the Affiliated Hospitals do not alleviate any of the District's legal obligations. Consequently, the Affiliated Hospitals have not made a provider-related donation to the District because there is no voluntary contribution, in cash or in kind, direct or indirect, by the Affiliated Hospitals to the District.

Thank you again for allowing us to submit this information. We have included with this letter the additional documents that CMS has requested regarding TBACS. If HHSC or CMS requires anything more, please let us know.

Sincerely,

Driscoll Children's Hospital

Corpus Christi Medical Center, through its owner and operator, Bay Area Healthcare Group, Ltd.

Victoria of Texas, L.P. d/b/a DeTar Healthcare System

cc: Monica Leo
Special Counsel to Systems Support
Texas Health & Human Services Commission
Mail Code 1070
4900 N. Lamar Blvd., 4th Floor
Austin, Texas 78751

EXHIBIT 4

OVERVIEW OF 2012 SPOHN MEMBERSHIP AGREEMENT SUBMITTED ON BEHALF OF CHRISTUS SPOHN HEALTH SYSTEM CORPORATION AND NUECES COUNTY HOSPITAL DISTRICT

NOTE: This document is intended to describe the history, background, and objectives for the negotiations among CHRISTUS Spohn Health System Corporation ("Spohn"), CHRISTUS Health, and the Nueces County Hospital District ("District") that resulted in the transformation of the ownership and operations of Spohn as implemented through the October 1, 2012 Spohn Membership Agreement and the ensuing improvements in the delivery of healthcare services in Nueces County. This draft is intended solely as a discussion document for purposes of informing the Texas Health and Human Services Commission and the Centers for Medicare and Medicaid Services of such history, purposes, and objectives, and both Spohn and the District reserve the right to revise or supplement this Overview as they determine appropriate.

I. *Background*

Nueces County serves as the primary urban center of the State's Regional Healthcare Partnership 4 ("RHP Region 4") serving the Coastal Bend communities of South Texas. Historically, the Nueces County Hospital District ("District") owned and operated Memorial Medical Center located in Corpus Christi, Texas ("Memorial") and served as the regional, public safety-net hospital providing indigent care services to the needy residents of Nueces County and uncompensated care to residents of other surrounding counties. As a Chapter 281 hospital district, the District is a "unit of local government" granted discretionary authority to operate, purchase, lease or sell hospitals or otherwise provide or arrange for the provision of health care services in support of its statutory indigent care obligation. Under the Social Security Act, as amended, and the administrative rules of the Centers for Medicare and Medicaid Services ("CMS") and the Texas Health and Human Services Commission ("HHSC"), the District is also eligible to make intergovernmental transfers ("IGTs") of funds for the nonfederal share of Medicaid supplemental payments.

CHRISTUS Spohn Health System Corporation ("Spohn") is also located in Corpus Christi, Texas and has a history of providing health care services to the uninsured and underinsured in Corpus Chrsiti and the surrounding Coastal Bend communities for over 100 years.

In 1996 through a series of agreements (the "1996 Transaction"), the District started a collaborative, team relationship with Spohn to optimize the operations of both organizations. Through the 1996 Transaction, the District transferred the clinical operations of and leased the 341-bed Memorial hospital, the District's four neighborhood outpatient clinics, and the District's physician office building infrastructure to Spohn. Spohn combined its existing facilities in the Corpus Christi community with the District's facilities and operated the entire enterprise as a single hospital provider under the District's historical provider number. Combination of the various facilities under Memorial's multi-campus license and provider agreements allowed the parties to consolidate and coordinate the delivery of care to the low-income population throughout Nueces County at a reduced cost. Consolidation also allowed Spohn to continue and

expand Memorial's graduate medical education and residency programs, and to expand the capabilities of Memorial's trauma program, the region's only Level II Trauma Program that advanced from Level III to Level II status under Spohn's operation. Since 1996, Spohn has served as the largest public provider in South Texas and was classified by HHSC as a governmental hospital for purposes of participation in the Medicaid disproportionate share hospital ("Medicaid DSH") and Medicaid supplemental payment ("Medicaid UPL") programs. The Texas Legislature also acknowledged Spohn's public status by granting Spohn governmental unit status and corresponding governmental immunity as a hospital district management contractor for the purposes of Chapters 101, 102, and 108 of the Texas Civil Practice & Remedies Code.[1]

Changes in reimbursement considered and proposed in 2011 and 2012 (e.g., state-wide roll-out of Medicaid managed care, elimination of the Medicaid public and private hospital upper payment limit ("UPL") programs, reductions in Medicaid disproportionate share hospital ("DSH") payments) resulted in the development of the Texas Healthcare Transformation and Quality Improvement Program Medicaid Section 1115 Demonstration Waiver ("Waiver") and prompted the District and Spohn to expand their collaborative, team relationship to then include the sharing of economic risk for Spohn's operations and deployment of capital resources for transformation of the safety-net hospital system in Nueces County.

At that time, Spohn faced significant capital costs due to the deteriorating condition of its facilities, particularly the Memorial infrastructure. Spohn's options to address these capital needs were somewhat limited by the 1996 Transaction documents, through which Spohn assumed a 30-year responsibility for the maintenance and operations of the Memorial facility. In addition to the lease rate for the Memorial facility and the District's other assets and Spohn's obligation to maintain the facilities in a commercially reasonable manner, Spohn had also agreed to invest at least $6 million per year in capital improvements and equipment at the Memorial campus, the neighborhood clinics, and the physician office buildings. In 2011, Spohn began the process of evaluating a transformative capital project in the Nueces County market, with the goal to shift the delivery of care towards a focus on more appropriate outpatient care venues and better coordination across the care continuum, rather than simply retrofitting the existing hospital inpatient infrastructure. In order for the parties to make significant changes to the infrastructure, Spohn desired more flexibility than what was available under the 1996 Transaction documents; in particular, it desired to align the interests of the District and Spohn more closely and to relax or remove its contractual commitment to maintain the existing facilities, including the Memorial facility owned by the District, as they were. CHRISTUS Health, Spohn's parent organization, ultimately approved a $325 million capital investment in 2013 in the Corpus Christi market, after Spohn's transition to the co-membership/ownership role with the District discussed below.

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[1] TEX. HEALTH AND SAFETY CODE §§ 285.071 (defining a hospital district management contractor) and 285.072 (providing that a hospital district management contractor is "considered a governmental unit for purposes of" governmental immunity under Chapters 101, 102, and 108, Civil Practice and Remedies Code); *see also Rodriguez v. CHRISTUS Spohn Health System Corp*., 628 F. 3d 731, 734 (5th Cir. 2010) and *CHRISTUS Spohn Health System Corporation v. Ven Huizen*, No. 13-10-400-CV, 2011 WL 1900174 (Tex. App.—Corpus Christi May 19, 2011).

Recognizing the constraints placed on their strategic planning efforts due to the historical structure, the parties invoked the process outlined in the 1996 Transaction that allowed for the District and Spohn to renegotiate the agreements between the parties in the event there was an adverse material change in government reimbursement. This provision was originally included in the 1996 Transaction due to uncertainties surrounding the future of health care reimbursement attendant to the Universal Health Care initiatives proposed at the initial stages of the Clinton administration. The parties therefore included in the 1996 Transaction documents a right to renegotiate changes in their relationship in the event there was a substantial reduction in government program funding for Spohn, like the potential adverse impact predicted in 2011 and 2012 to Spohn's historical UPL and Medicaid DSH funding and the uncertainties attendant to the development of and transition to the Waiver. On invoking this process to assess the risk of adverse material change in government reimbursement to Spohn, the parties also identified opportunities to improve the delivery of care in the Coastal Bend communities.

II. *Structure of 2012 Spohn Membership Agreement*

The parties structured the 2012 Spohn Membership Agreement in further support of their efforts to more closely and comprehensively collaborate and align the operations of the District and Spohn as a governmental and public provider. Effective September 30, 2012, the parties entered into a Memorandum of Understanding to effectuate termination of the 1996 Transaction agreements.[2] At the same time, they entered into the 2012 Spohn Membership Agreement, effective October 1, 2012, pursuant to which the District became a co-member[3] in Spohn along with CHRISTUS Health,[4] with the rights, privileges, obligations, and duties attendant to such role. The parties intended that Spohn would continue to serve as the public safety-net hospital in Corpus Christi, as set forth in Section 1.01 of the 2012 Spohn Membership Agreement. In order to reflect the District as a co-member in Spohn, the parties revised Spohn's corporate documents,[5] and submitted the appropriate enrollment change documents to the Medicare fiscal intermediary and the State related to its Medicare and Medicaid provider agreements.[6] The District also provided Spohn with the right to continue to use and operate the Memorial facilities[7] and granted Spohn the right to make material alterations to the Memorial facilities upon reasonable review of the District.[8] The District also agreed to reduce Spohn's obligation to make $6 million in capital expenditures per year for Memorial and the District's other facilities in the event such material alterations were made.[9]

The parties agreed that each co-member of Spohn was entitled to an allocated portion of the funds as part of their co-membership/ownership role, commensurate with their liability for

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2 Section 2.05 of the 2012 Spohn Membership Agreement.

3 A co-member of a Texas nonprofit corporation is analogous to that of a shareholder in a Texas business corporation.

4 Section 2.02 of the 2012 Spohn Membership Agreement.

5 Both the Certificate of Formation (replacing the former Articles of Incorporation) and the Bylaws were revised and attached as Exhibits A and B, respectively, to the 2012 Spohn Membership Agreement.

6 The PECOS system enrollment records show the Change of Information effective October 1, 2012 that added the District as a co-member in Spohn for each of the facilities Spohn operates.

7 Section 2.03 of the 2012 Spohn Membership Agreement.

8 Section 3.8.6 of Schedule 1 to the 2012 Spohn Membership Agreement.

9 *Id*.

Spohn's operating losses.[10] Specifically, under the 2012 Spohn Membership Agreement, the co-members agreed to remit to Spohn their pro rata share of any operating loss deficits within a specified timeframe. Upon implementation of the 2012 Spohn Membership Agreement, CHRISTUS Health and the District were co-members in the Spohn corporate entity. CHRISTUS Health continued to receive its management fees and other revenue from Spohn's operations in return for the support services it furnished to Spohn. In exchange for the District's support of Spohn and its assumption of economic risk[11] and the various tangible and intangible economic and other benefits the District granted to Spohn described in this Overview, the District was entitled to an allocated portion of the funds Spohn had available for distribution to its co-members—i.e., a share of the Spohn nonfederal net patient revenue negotiated annually based on Spohn's operating budget and projected operating margin for the upcoming year.[12] Any funds distributed to the District came solely from bank accounts in the name of Spohn.[13] The District prepared its annual budgets incorporating the projected co-member distributions the District expected to receive under the 2012 Spohn Membership Agreement and such budgets were considered and approved by the Board of Managers of the District and the Nueces County Commissioners Court in public sessions under the Texas Open Meetings Act.

In order to ensure that the District had the flexibility to use any funds distributed to the District in its role as co-member of Spohn without restriction, the parties established a methodology to distribute funds to the District from Spohn's nonfederal net patient funding each week. The amount of funds distributed each week was a fixed percentage of the total nonfederal net patient revenue, negotiated annually between the parties based on Spohn's operating budget and projected operating margin for the upcoming year.[14] The parties elected to base the distributions on Spohn's nonfederal net patient revenue, assuming that all of the funds distributed to the District would meet the federal definition of "public funds,"[15] should the District elect to use any of such funds for the nonfederal share of Medicaid payments for Spohn or other RHP Region 4 providers. Furthermore, the District retained the sole and unrestricted discretion to use its share of the Spohn co-member distributions in any way it chose, whether to use the funds, to pay for or provide indigent care, to support Spohn, or for any other permissible purpose for a Chapter 281 hospital district, including the support of other RHP Region 4 providers. Consistent with such unrestricted discretion, the District sought and obtained an amendment of its governing statute in 2013 to confirm that the District had statutory authority to make IGTs in support of RHP Region 4 providers inside or outside of Nueces County.[16]

The Board of Managers of the District, subject to any required review or approval by the Nueces County Commissioners Court, possesses the authority to work with Spohn to provide care to the indigent in the community, whether through contractual agreements with Spohn, as historically in effect, or through a co-membership/ownership role in the Spohn corporate entity as provided

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10 Section 2.04 of the 2012 Spohn Membership Agreement.
11 Section 2.04 of the 2012 Spohn Membership Agreement.
12 Section 7.03 of the 2012 Spohn Membership Agreement.
13 Section 7.01 of the 2012 Spohn Membership Agreement.
14 Section 7.03 of the 2012 Spohn Membership Agreement.
15 Section 7.02 of the 2012 Spohn Membership Agreement; *See*, 42 C.F.R. § 433.51, for CMS rule, and 1 Tex. Admin Code § 355.8068(b)(12), for HHSC rule.
16 TEX. HEALTH AND SAFETY CODE § 281.094(b).

in the 2012 Spohn Membership Agreement. Hospital district boards are granted authority to determine how best to utilize their resources to meet the healthcare needs of their indigent population and may operate, purchase, lease or sell hospitals or otherwise provide or arrange for the provision of health care services as part of their statutory mission.[17] The transition to co-membership in Spohn is consistent with the Board of Managers' authority and is permitted by Texas law. While the District is a special purpose district, both statutory law and analogous Texas Attorney General opinions support the authority afforded to the District to implement the co-member transaction described above.

III. *The 2012 Spohn Membership Agreement Resulted From Arm's Length Negotiation and is Commercially Reasonable.*

The 2012 Spohn Membership Agreement resulted in benefits to Spohn that were reasonably anticipated to exceed the co-member distributions that the District would receive under the Spohn Membership Agreement and, in their totality, these benefits demonstrate the commercial reasonableness of the transaction. Following are a summary of certain of the significant benefits to Spohn from its agreement to add the District as Spohn's co-member:

- A significant portion of the collaborative relationship between the District and Spohn involved sharing both the risks and benefits of Spohn's operations between the two co-members. The parties established the co-members' sharing ratio each year based on Spohn's operating budget and projected operating margin for the upcoming year, taking into account its operations in the prior year. In the 2012 Spohn Membership Agreement, the District agreed to share in the economic risk of Spohn's operations and acquired financial liability to support Spohn in the event Spohn incurred economic losses. Specifically, Section 2.04 of the 2012 Spohn Membership Agreement provides that the District, as co-member, will remit its pro rata share of any "Net Operating Deficit" to Spohn, with its pro rata share equaling the same "Specified Annual Percentage" used for co-member distributions of Spohn's nonfederal net patient revenue in that year (based on Spohn's operating budget and projected operating margin).[18]

- Spohn obtained the right to propose and make material alterations to the Memorial facility, subject to reasonable review of the District. By 2012, the Memorial facility was showing signs of deterioration, given both the age of the facilities and the impact of several hurricanes in the area since the construction of the Memorial Facility. Spohn engaged several consultants to identify options for restructuring its healthcare delivery facilities in Nueces County and to identify the best options for improving the quality of care while minimizing the overall capital outlay required. Preliminary findings suggested that the Memorial facility alone would require a minimum of $400 million to refurbish, and $600 million to replace, the Memorial facility to ensure it continued to meet Spohn's standards for patient safety and quality of care. However, because Spohn

[17] TEX. HEALTH AND SAFETY CODE § 281.051. See also Tex. Att'y Gen. Letter Op. LO-97-17 (1997); Tex. Att'y Gen. Letter Op. DM-37 (1991); Tex. Att'y Gen. Letter Op. LO-88-33 (1988); Tex. Att'y Gen. Letter Op. JM-816 (1987).

[18] Section 2.04 of the 2012 Spohn Membership Agreement.

did not own the Memorial facility, Spohn's ability to repurpose the Memorial facility campus was limited.

The parties added new provisions in Schedule 1 of the 2012 Spohn Membership Agreement that authorized Spohn to propose and proceed with material alterations of the Memorial facility.[19] Spohn's management worked diligently to identify opportunities to invest the bulk of its estimated $325 million capital campaign funds approval by its parent CHRISTUS Health, in facilities or improvements that Spohn determined would most appropriately accomplish Spohn's desired infrastructure improvements and result in the transformation in the delivery of healthcare services in Nueces County. While retrofitting Memorial was a potential alternative, Spohn neither owned the Memorial campus nor believed the $400 million-plus investment would achieve the desired transformation of the healthcare delivery system in Nueces County. The consultants' analysis confirmed that the Nueces County market had excess inpatient bed capacity and outdated facilities for delivery of more specialized trauma and other hospital services. Consequently, the ability to replace the Memorial facility with a lower-cost, modern outpatient clinic suitable for the type of care needed in the community was of significant strategic value to CHRISTUS Health and Spohn when deciding to enter into the 2012 Spohn Membership Agreement and provided a roadmap for Spohn to use its capital campaign funds for more transformative projects in the community. In fact, development of the transformation of the facilities is underway, and the parties are actively working on this multi-year project.

- Spohn's contractual obligation under the 1996 Transaction documents to pay physicians for indigent care in Nueces County was also superseded and restated in the Spohn Membership Agreement. Under the 1996 Transaction documents, Spohn was contractually required to directly provide indigent care services at its facilities and to directly pay physicians for professional services to eligible Nueces County indigent patients. By 2012, Spohn estimated that the payments Spohn received from the District for Nueces County indigent care under the 1996 Transaction documents were approximately $20 million less than its annual cost to Spohn of providing Nueces County indigent care. Entering into the Spohn Membership Agreement enabled Spohn to continue[20] to provide or arrange for the provision of Nueces County indigent care while also permitting other providers in the community to provide health care services, in their discretion, to the indigent in Nueces County, independent of Spohn's contractual commitment to the District.[21] Spohn estimated that such modification of the contractual obligation to provide Nueces County indigent care allowed Spohn to reduce its costs by at least $20 million annually.

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[19] Section 3.8.6 of Schedule 1 to the 2012 Spohn Membership Agreement.

[20] Under the 2012 Spohn Membership Agreement, Spohn continues to provide safety-net hospital services to the Nueces County indigent population but is no longer legally obligated to pay third parties for their indigent care services. Sections 8.01 and 8.03 of the 2012 Spohn Membership Agreement.

[21] Termination of Spohn's contractual obligation to pay physicians for indigent care is consistent with applicable rules from both CMS and HHSC in 2012.

- In lieu of leasing the District-owned facilities under the 1996 Transaction, the District granted Spohn the right to use and occupy the Memorial facility and other District-owned clinics and office buildings without payment of rent as part of the 2012 Spohn Membership Agreement.[22] By terminating the prior lease, Spohn no longer had a specific obligation to pay rent for the Memorial facility to the District, a savings of $6 million annually (and up to $84 million over the remaining term of the prior Lease Agreement).

- In Schedule 1 of the Membership Agreement,[23] the parties also agreed that in the event of material alterations to the Memorial facilities, Spohn's obligation under the Membership Agreement to make $6 million in annual capital expenditures for the Memorial and other District facilities would be reduced. In accordance with the 2012 Spohn Membership Agreement, upon approval of the material alterations, the District agreed in a letter of intent between the parties to significantly reduce Spohn's annual capital expenditure obligation, a potential savings to Spohn of over $60 million from 2015 through 2026.[24]

The arm's length negotiation of the 2012 Spohn Membership Agreement also resulted in certain significant benefits to the District. These include:

- The District, through its appointed representatives on the Spohn Board, is able to actively participate in a constructive manner in the operations of Spohn in furtherance of the District's and Spohn's comprehensive collaborative relationship;

- Confirmation in the above-referenced letter of intent approving Spohn's proposed material alterations of the Memorial campus that Spohn's commitment to provide or arrange for the provision of indigent care services to the needy residents of Nueces County extends beyond the 2026 termination date of the 1996 Transaction documents until at least 2036;

- The replacement of the aged Memorial hospital facility within the Corpus Christi community will be accomplished through Spohn's recently announced $325 million capital infrastructure and health care delivery improvement project in Corpus Christi; and

- The District's historical support of the Coastal Bend health care provider community will continue including the District's service as RHP Region 4 Anchor.

Aside from the quantifiable benefits to Spohn and the District, the transition to the District's co-membership/ownership role in Spohn further aligned the interests of the District and Spohn, thereby providing the more robust and comprehensive collaboration necessary to focus efforts on improving the delivery of care by providing more suitable health care services to improve the health of the community at a lower cost.

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22 Section 8.02 of the 2012 Spohn Membership Agreement.
23 Section 3.8.6 of Schedule 1 of the Spohn Membership Agreement.
24 Section II.d of the Letter of Intent Regarding Material Alteration Notice.

Finally, the parties diligently sought the review and confirmation of HHSC throughout the process of developing the 2012 Spohn Membership Agreement. The parties sent proposition papers to HHSC, sought HHSC input in the plans, met with HHSC representatives on multiple occasions, and submitted the final 2012 Spohn Membership Agreement to HHSC for review and concurrence prior to its execution. The congratulatory and confirming communications received by the District and Spohn from the HHSC Commissioners during 2012 are attached to this Overview as Exhibits A and B.

IV. *Conclusion.*

As described in more detail above, the 2012 Spohn Membership Agreement was negotiated at arm's length in the ordinary course of business among the parties for bona fide and commercially reasonable business reasons unrelated to the Waiver and continued the evolution of the collaborative relationship between the District and Spohn that began in 1996. Consequently, the parties believe the 2012 Spohn Membership Agreement is consistent with applicable federal and state law and the co-member distributions to the District do not constitute impermissible provider-related donations.

EXHIBIT 4a

EXHIBIT A

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

THOMAS M. SUEHS
EXECUTIVE COMMISSIONER

August 31, 2012

The Honorable Samuel L. Neal, Jr.
Nueces County Judge
901 Leopard Street, Room 303
Corpus Christi, Texas 78401

Jonny F. Hipp, CEO
2606 Hospital Boulevard
Corpus Christi, Texas 78405

Pamela S. Robertson, President and CEO
CHRISTUS Spohn Health System
1702 Santa Fe
Corpus Christi, Texas 78404

Dear Judge Neal, Mr. Hipp, and Ms. Robertson:

I want to congratulate you on the development of the Spohn Membership Agreement to support the greater Corpus Christi and Nueces County area's participation in the Texas 1115 Medicaid Transformation Waiver. My staff currently is reviewing the Agreement, but the initial feedback I have received from them confirms the hard work and commitment each of your organizations has made to ensure the successful implementation of the waiver.

I am also pleased that the Agreement represents a truly public-private partnership that ensures not only the continuity of critical care for the community, but also the public funding of payments under the Waiver, and it does so in a transparent and accountable way. I hope that this can become a model for other communities to emulate.

I appreciate your sharing the news of your success with me. Please be assured that the Health and Human Services Commission will continue to support your efforts to innovate and transform the delivery of care to your constituents.

Sincerely,

Thomas M. Suehs

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Austin, Texas 78751 • (512) 424-6500

EXHIBIT 4b

EXHIBIT B

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

October 12, 2012

The Honorable Samuel L. Neal, Jr.
Nueces County Judge
901 Leopard Street, Room 303
Corpus Christi, Texas 78401

Jonny F. Hipp, CEO
2606 Hospital Boulevard
Corpus Christi, Texas 78405

Pamela S. Robertson, President and CEO
CHRISTUS Spohn Health System
1702 Santa Fe
Corpus Christi, Texas 78404

Dear Judge Neal, Mr. Hipp, and Ms. Roberston:

Congratulations on your completion of the agreement for the continuation of the partnership between CHRISTUS Spohn and the Nueces County Hospital District to serve the needy residents of Nueces County, the Coastal Bend, and South Texas. I share former Executive Commissioner Tom Suehs' enthusiasm for your efforts, and we look forward to your participation in the Texas 1115 Medicaid Transformation Waiver. We share your goal of improving access to high quality health care, and we are pleased to see such close collaboration.

My staff inform me that, the terms of the draft agreement that your attorneys shared with us last month offers a method for the revenue of the facilities soon-to-be jointly operated by CHRISTUS Spohn and the district to be allocated in a manner that is intended to assure the availability of public funds to help finance payments under the waiver. Staff also advises that under the draft agreement the district has the discretion to use the allocated revenue for any purpose it chooses, including the use of those funds as the non-federal share of a Medicaid supplemental payment. Based on these representations and the assurances of counsel to your organizations, my staff advises that the revenue so produced would appear to meet the definition of "public funds" in accordance with administrative rules that govern the operation of the waiver.

My staff noted one minor discrepancy between the draft agreement and the draft certification that counsel to your organizations prepared for our review and consideration. The agreement describes "net patient revenue" as exclusive of the federal share of any Medicaid payments – meaning that the non-federal share of such payments would be treated as net patient revenue. The proposed certification, however, states that "net patient revenue" excludes *all* Medicaid reimbursement.

Although it is not clear whether parties intend to allocate some of none of the Medicaid payments paid for services to Medicaid recipients who receive care at the jointly-operated facilities, the critical representation contained in both documents is that *no federal money* will be allocated to the district under the agreement. Thus, the agreement on its face attempts to assure that an intergovernmental transfer derived in whole or in part from the shared net patient revenue complies with federal requirements that govern such transfers. We appreciate counsels' attention to these important details.

Again, please accept my congratulations for a remarkable achievement. Steve Aragon, Chief Counsel, serves as the lead staff on this matter and can be reached by telephone at (512) 424-6578 or by e-mail at Steve.Aragon@hhsc.state.tx.us.

Sincerely,

Kyle L. Janek, M.D.