TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

October 31, 2014

Ms. Cindy Mann
Director, 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 Ms. Mann:

The Texas Health and Human Services Commission (HHSC) is writing to address the issue of the September 24, 2014 deferral of Uncompensated Care (UC) payments (2014 Deferral).[1] As we understand the issue, CMS is concerned that participants in the Texas Healthcare Transformation and Quality Improvement Program (1115 Waiver) are involved in financial arrangements that lead to improper provider related donations in violation of Section 1903(w) of the Social Security Act.

Through this letter, we hope to impart three key points. First, if this deferral becomes a disallowance, it will have devastating consequences to the 1115 Waiver, healthcare providers and Medicaid recipients. Second, as far as HHSC is aware, participating providers are complying with all federal statutes and regulations regarding provider related donations. Third, we relied heavily on CMS' approval of the relationships at issue in the 2014 Deferral when we created the 1115 Waiver. As such, HHSC requests that CMS lift the deferral as soon as possible.

I. HHSC requests a prompt resolution to the 2014 Deferral.

HHSC is working diligently to respond to the Dallas CMS Regional Office's request for additional documents. In addition, HHSC made attempts to work with the Regional Office to determine what documents or information will assist in providing assurances and clarifications to CMS so that CMS is comfortable lifting the deferral and the 1115 Waiver may continue its success unabated. A resolution to this deferral by December is crucial if the upcoming Delivery System Reform Incentive Payments (DSRIP payments) are to be made to any of the private providers involved in the program.

[1] Letter to Kay Ghahremani from Bill Brooks dated Sept. 30, 2014, regarding Deferral #TX/2014/3/E/03/MAP.

II. The 1115 Waiver utilizes elements of the Private Hospital Upper Payment Limit (UPL) supplemental payment program in Texas to transform the healthcare system.

HHSC negotiated with CMS to create the 1115 Waiver. As you are aware, in addition to expanding Medicaid managed care, the 1115 Waiver allowed for the creation of two supplemental payment pools, UC and DSRIP. The UC and DSRIP pools replaced the Private Hospital UPL program, which could not continue if the expansion of managed care were to occur. HHSC was clear at the time of the negotiations that it would not expand Medicaid managed care *unless the funding to Texas hospitals from the Private Hospital UPL program continued to be available in some form.*

UC and DSRIP provide CMS with a number of advantages over the Private Hospital UPL program. First, both the UC and DSRIP pools are capped in each demonstration year. Therefore, CMS enjoys a level of fiscal certainty that did not exist prior to the 1115 Waiver. Second, UC payments to providers are capped by the costs of services. Some UPL payments were capped by the charges associated with those services. Finally, DSRIP funds are earned for approved metrics around healthcare delivery transformation, and as such, improve access and encourage innovation to find better ways to deliver care.

Throughout the Private Hospital UPL program, the non-federal share of the supplemental payments were financed through intergovernmental transfers (IGTs) provided by local governmental entities (IGT Entities), such as counties and hospital districts. As CMS was aware prior to the approval of the Private Hospital UPL program, private hospitals band together to form non-profit corporations whose sole purpose is to provide care to the indigent. In the Private Hospital UPL program, the non-profit corporations would provide or pay for the healthcare to the indigent of a given area. The provision of such indigent care might result in a tax savings for the IGT Entities. The IGT Entities could choose to provide those tax dollars as the non-federal share of the Medicaid supplemental payment. As HHSC represented to CMS in in a 2008 letter, "[t]he 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."[2]

HHSC negotiated safeguards and protocols with CMS in 2008 and implemented them in the same year to add transparency and accountability to the Private Hospital UPL program. HHSC required these exact safeguards to continue in the 1115 Waiver and is unaware of any point during the 1115 Waiver negotiations at which CMS expressed a concern with the indigent care model. Thus, HHSC relied on CMS' prior approval of the model to plan for the participation of private hospitals in the waiver. In fact, paragraph 45(a)(i)(C)(I) of the 1115 Waiver Standard Terms and Conditions requires private providers to have an executed indigent care affiliation agreement to be eligible for UC payments.

III. The continued success of the 1115 Waiver depends on the participation of private hospitals.

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[2] Letter to Bill Brooks from Chris Traylor dated Feb. 4, 2008, regarding deferral #TX/2007/3/E/12/MAP, at p. 2.

Although the 2014 Deferral relates to UC payments in three regions of the state, all other Waiver payments to private providers throughout the state are at risk. Private hospitals accounted for $2.25 billion in UC payments in the second year of the waiver. That amount is over half of all UC payments made for that year. Those payments represent a substantial amount of reimbursement for uncompensated costs already incurred by the affected hospitals for services provided to Medicaid-enrolled and uninsured patients. Many of the major safety net hospitals[3] receive these payments, so much so that the safety net of the Texas healthcare system is imperiled if CMS revokes its approval of private hospital funding arrangements.

In fact, private hospitals account for the majority of inpatient care for Medicaid beneficiaries and the indigent. According to 2013 Disproportionate Share Hospital (DSH) data, private hospitals accounted for 79.5% of all Medicaid inpatient days for Texas DSH participants. Clearly, private hospitals play an enormous role in the Texas safety net and ending 1115 Waiver payments is dangerous for the Medicaid recipients and indigent of Texas.

The private performing providers in the DSRIP program are in a particularly difficult position. HHSC advocated for DSRIP to be completely optional, but CMS required a minimum level of private hospital participation in every region. DSRIP is inherently risky for any performing provider because a significant investment is typically required at the beginning of a DSRIP project. Since the DSRIP payments are incentive based, a performing provider only receives a return on that investment if a metric approved by both HHSC and CMS is met.

That risk is even greater for a private performing provider because it must also contend with the possibility that the IGT Entity might not provide the non-federal share of a properly earned DSRIP payment.[4] A private performing provider has no reason to continue with its investment in DSRIP projects if there is no hope for future incentive payments.

Private entities account for about $3.15 billion in DSRIP allocation throughout the five years of the 1115 Waiver (or, about one third of all available DSRIP funds). That $3.15 billion is allocated to 464 DSRIP projects (again, about one third of all DSRIP projects). So far, private entities have been paid about $640 million in DSRIP funds. However, the final years of the 1115 Waiver measure the outcomes of the DSRIP projects, a topic of keen interest to both HHSC and CMS. Thus, while private entities have already earned a significant amount of incentive payments, the most valuable metrics have yet to be performed.

Absent evidence that the collaboration model CMS approved for Private Hospital UPL is not being followed, to revoke approval more than two years into the waiver would not only be inequitable, it would be devastating to the continuing success of the 1115 waiver. Thousands of Medicaid recipients and indigent individuals in Texas rely on the care made possible through UC and DSRIP.

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[3] The definition of "major safety net hospital" was agreed to by both HHSC and CMS.

[4] A governmental entity has the absolute right to refuse to provide an IGT on behalf of a private entity (community benefit or not). In fact, a cornerstone of HHSC's protocol for participation by a private hospital in the waiver is that no agreement exists to condition the community benefit provided by the hospital on a transfer by the governmental entity to support a waiver payment.

IV. Texas providers are in compliance with CMS' longstanding interpretation of federal law and continue to rely on that interpretation.

In explaining the reasoning behind the 2014 Deferral, CMS states that "[i]t appears that the [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."[5] This is a novel standard for impermissible provider related donations. CMS points to recent guidance from State Medicaid Director Letter #14-004 (SMDL) as the source for this new standard.

HHSC reviewed the SMDL extensively and believes that it provides some valuable guidance. For example, CMS describes a scenario wherein a private hospital leases space from a governmental entity for an amount above the fair market value of the property. The lease payments would, in turn, be used by the governmental entity as the non-federal share of a Medicaid payment. HHSC agrees that this arrangement would violate provider related donation laws. HHSC continually stresses the importance of fair market contracting with all 1115 Waiver participants.

However, the other example in the SMDL is concerning. It discusses a scenario in which a public entity terminates a contract and a private hospital signs a new contract to conduct the same services that the public entity formerly provided. Although the description is vague, CMS apparently believes that it applies to several of the relationships in Texas.

HHSC disagrees that the limited fact scenario in the SMDL, without more, establishes the existence of a donation at all. (*See* discussion in Section V of this letter.) It is unfair for CMS to defer payments on this basis given CMS' longstanding prior approval of these same arrangements.

In negotiating the 1115 Waiver, HHSC and Texas providers relied on the previously established policy that CMS allowed through approving the Private Hospital UPL state plan amendments (SPAs) and in lifting a strikingly similar deferral in 2007 (2007 Deferral). HHSC believes that CMS' previous approval of the indigent care model reflects the correct interpretation of federal law; *i.e.,* that the provision of indigent care by a private hospital, in and of itself, does not establish the existence of a donation.

A. CMS was aware of the existence of indigent care agreements during the negotiations to create the Private Hospital UPL program.

There is ample evidence that CMS has not previously considered the provision of care to the indigent, by itself, to be a donation at all. For example, during negotiations in 2005 and 2006 for the SPAs concerning the creation of the Private Hospital UPL program[6,7], HHSC clearly described the method of financing the non-federal share of the supplemental payments. In response to a Request for Additional Information (RAI), HHSC stated:

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[5] Letter dated September 30, 2004, at p. 1.
[6] TN 05-001
[7] TN 05-011

> An indigent care agreement is the agreement between the [local government] and a group of local private hospitals...*to develop a plan for the [private hospitals] to alleviate the [local government's] tax burden by providing care to the indigent*, thereby allowing the [local government] to utilize its ad valorem tax revenue to fund the Medicaid program.[8]

The two SPAs were subsequently approved by CMS with language *in the state plan* requiring that private providers have indigent care agreements (ICAs) with a local governmental entity.

B. CMS lifted the 2007 Private Hospital UPL program deferral after extensive inquiry into the operation of the Texas indigent care model.

CMS issued the 2007 Deferral of Private Hospital UPL payments claiming "private hospitals may be satisfying certain fiscal obligations that are otherwise those of local governments."[9] HHSC and Texas stakeholders worked closely with CMS to end that deferral. As we explained at the time, HHSC understood CMS' acceptance of the SPAs to include acceptance of the fact that private entities could provide care to the indigent and the IGT Entities could separately provide the non-federal share of a Medicaid payment.[10] HHSC continued to defend the legality of the affiliations throughout the 2007 Deferral and worked with CMS to tailor a method by which they could become more comfortable with the affiliations. The result was the conditions of participation and certifications that were required of all Private Hospital UPL participants.[11] *CMS subsequently lifted the deferral.*

Thus, prior to negotiating for the 1115 Waiver, CMS conducted two inquiries of the Private Hospital UPL program on the very issue involved in the 2014 Deferral. After both inquiries, CMS allowed Texas stakeholders to continue utilizing the ICAs and allowed for the affiliated IGT Entities to be the source of the non-federal share of supplemental payments to the affiliated private hospitals. As far as we are aware, these arrangements continue to comply with the standards set out in the negotiations to end the 2007 Deferral.

V. There is no donation, let alone an impermissible provider-related donation.

Correspondence from CMS regarding the 2014 Deferral presupposes the existence of a donation from private hospitals to IGT Entities. As was explained during the 2007 Deferral, the ICAs that have taken root throughout much of the state do not violate provider related donation laws because there is no donation at all, let alone a non-bona fide donation.

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[8] Letter to Andrew Fredrickson from David Balland dated June 30, 2006, regarding Transmittal Number 05-011, at p. 4, (emphasis added).
[9] Letter to Chris Traylor from Bill Brooks dated Oct. 5, 2007, regarding Deferral #TX/2007/3/E/12/MAP, at p. 1.
[10] Letter dated February 4, 2008, at p. 3.
[11] Letter to James Frizzera from Chris Traylor dated May 1, 2008, regarding deferrals ## TX/2007/3/E/11/MAP, TX/2007/3/E/12/MAP, TX/2007/4/E/15/MAP.

In essence, the provision of care to the indigent by a private hospital can only constitute a provider related donation if it is provided as a benefit to the local governmental entity that is obligated to pay for or provide such care. A local governmental entity such as a county or a hospital district is not obligated to pay for all indigent care; only for indigent care that is not provided or paid for by some other entity.[12]

The non-profit organizations at the heart of the 2014 Deferral voluntarily provide or pay for care to the indigent in their areas. As such, no obligations to provide care for the indigent accrues for the local governmental entity in those areas. If there is a donation to anyone in this model, it is to the indigent of Texas, not the governmental entities.

Local governmental entities have limited budgets and might not be able to afford to both aid their local private hospital as well as provide for certain other healthcare services. Assume, for instance, that there is a need for periodic dental screenings in the areas of a county with poor financial and physical access to dentists. The county government would like to provide for a mobile dental clinic but might not have all of the skill or resources to do so. The local private hospital, however, has the skills and resources to provide for such a mobile clinic. The provision of such a service is a tremendous benefit to the people of the county that otherwise might not receive such care. The local governmental entity may choose to IGT on behalf of the private hospital for supplemental payments.

But, if there is a risk that such provision of care could be construed as a "donation" to the county, then the supplemental payments that private hospital is receiving are at risk. Given the importance of those supplemental payments, the private hospital is forced to make a terrible choice: continue providing a valuable extra service to the community or potentially face closure. HHSC simply does not believe that such an outcome is in anyone's interests.

HHSC looks forward to continue working with CMS to resolve this matter in an expeditious manner. Please let us know what information we can provide so that the 1115 Waiver can continue succeeding for the people of the State of Texas.

Sincerely,

Kay Ghahremani
HHSC State Medicaid Director

[12] Texas statutes are clear on this matter. *See* 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.*" *See* Tex. Health & Safety Code § 61.060(c): "A public hospital is the payor of last resort...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.*"