TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHARLES SMITH
EXECUTIVE COMMISSIONER

October 28, 2016

Via certified mail

Mr. Bill Brooks
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

Re: Disallowance TX/2016/001/MAP

Dear Mr. Brooks:

Pursuant to Section 1116(e)(1) of the Social Security Act, the Texas Health and Human Services Commission (HHSC) requests reconsideration of Disallowance Number TX/2016/001/MAP. For the reasons explained below, HHSC asks the Administrator to reverse the disallowance decision of the Centers for Medicare & Medicaid Services (CMS).

I. Background

On September 1, 2016, CMS sent notice to HHSC of Disallowance Number TX/2016/001/MAP (the disallowance).[1] The amount of the disallowance is $26,844,551 in federal financial participation as reported on the CMS-64 quarter ending December 31, 2015. CMS believes that arrangements between the hospital districts that provide the non-federal share of uncompensated care (UC) waiver payments and the private hospitals that receive those payments constitute non-bona fide provider donations under federal law and under guidance issued by CMS in May 2014 in the form of a state Medicaid director letter (SMDL #14-004).

The funding of private hospital supplemental payments has been the subject of review by CMS on multiple occasions. A short history of this issue is important to understanding the bases for HHSC's request that CMS withdraw this disallowance.

[1] *See* Letter notifying HHSC of Disallowance TX/2016/001/MAP (September 1, 2016) (Exhibit 1).

Private Hospital Upper Payment Limit Payments

In 2005, HHSC submitted a state plan amendment to CMS proposing the private hospital upper payment limit (UPL) supplemental funding program. During discussions with CMS concerning the approval of this state plan amendment, CMS was fully informed that private hospitals would provide services to indigent patients that a governmental entity previously provided and that could result in extra funds on the part of a local governmental entity.[2] For example, HHSC disclosed to CMS in its June 30, 2006 response to CMS' Request for Additional Information:

> An indigent care agreement is the agreement between the Local [Governmental] Entity and a group of local private hospitals ("Affiliated Hospitals") to develop a plan for the Affiliated Hospitals to alleviate the Local [Governmental] Entity's tax burden by providing care to the indigent, thereby allowing the Local [Governmental] Entity to utilize its ad valorem tax revenue to fund the Medicaid program.[3]

Those extra funds then could, at the complete discretion of the local governmental entity, be used to fund the Medicaid program. The amendment was approved by CMS in 2006.[4]

CMS Deferral of Private Hospital UPL Payments in 2007

In 2007, CMS issued deferrals of UPL payments to private hospitals in Texas based on concerns that private hospitals were either donating funds or returning a share of Medicaid payments to the governmental entities that funded the non-federal share of the UPL payments. Arrangements in Dallas County were among those questioned by CMS.

In order to resolve the deferrals, HHSC worked closely with CMS and provided comprehensive disclosures regarding the funding sources. For example, HHSC described the private hospital UPL program to CMS in a February 4, 2008, letter as follows:

> 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

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[2] *See* Letter from HHSC to Andrew A. Frederickson, CMS, responding to Request for Additional Information (June 30, 2006)(Exhibit 2).
[3] *Id* at 4.
[4] *See* Letter from CMS to Chris Traylor, Associate Commissioner for Medicaid & CHIP, HHSC, approving State Plan Amendment 05-011 (September 5, 2006)(Exhibit 3).

> otherwise incur... thus relieved, [the local government entities] are able to contribute toward the support of Medicaid providers in their communities.[5]

HHSC also explained that private hospitals' decision to provide indigent care the governmental entity previously provided was not a legal obligation of the governmental entity, stating:

> These [governmental entity] contracts were terminated, after which the private hospitals... entered into new contracts with the providers ... with the money no longer being spent under the terminated contracts, the district was able to make an IGT to fund increased Medicaid payments.[6]

HHSC also implemented Conditions of Participation that prohibit any linkage between the indigent care private hospitals provide and any payments to the hospitals that participated in the UPL program, and they specifically prohibit the assignment of contractual or statutory obligations of the governmental entity to private hospitals. The Conditions of Participation also explicitly authorize private hospitals to provide indigent care by entering into their own arrangements with healthcare providers that had previously provided services to the governmental entity.

After extensive review by CMS of materials documenting and describing the funding relationships, and after working with Texas to develop the Conditions of Participation, CMS lifted the deferral. CMS' action constituted recognition that so long as public-private partnerships adhere to the disclosures to CMS, they are in compliance with federal law. The arrangements in Dallas and Tarrant Counties continue to operate in accordance with the terms of the Conditions or Participation disclosed to and approved by CMS.

Conversion of UPL to Uncompensated Care

In 2011, HHSC negotiated a five year Section 1115 demonstration waiver with CMS that, among other things, established funding for UC costs. Under the 1115 waiver, the UPL program was effectively converted to the UC program. Payments to private hospitals under the UC program are funded using the same funding mechanisms as were used under the former UPL program and under the same Conditions of Participation. Again, CMS approved the waiver with the knowledge that UC payments to private hospitals would be financed using those same funding mechanisms.[7]

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[5] *See* Letter from Chris Traylor to Bill Brooks, Acting Associate Regional Admin., CMS (Feb. 4, 2008)(Exhibit 4 at 2).

[6] *Id* at 5.

[7] *See* CMS Special Terms and Conditions for the Texas Healthcare Transformation and Quality Improvement Program section 1115(a) Medicaid demonstration, Number 11-W-00278/6, STC #44(a)(ii)(C)(I)(requiring that "[p]rivate providers must have an executed indigent care affiliation agreement on file with HHSC")(pertinent page attached as Exhibit 5).

2014 Deferral of Private Hospital Payments

In June 2014, CMS began conducting a financial management review of payments to private hospitals in three areas of the state, including Dallas and Tarrant Counties. CMS stated that they were relying on guidance in SMDL #14-004 to analyze Texas funding arrangements.

As a result of the financial review team findings, CMS sent Texas a letter deferring $74 million for UC payments made to private hospitals while it further investigated the source of the non-federal share of the payments. After discussions between HHSC and CMS, and CMS' review of additional requested documents from the private hospitals, CMS released the 2014 deferral.[8] CMS stated that release of the deferral did not constitute CMS' acceptance of the financing arrangements, but that CMS was willing to work with the state before making a final determination.

In May 2015, HHSC and CMS began a series of focused discussions evaluating the private hospital funding issue. During that process, CMS agreed that if changes to private hospital funding were required by CMS following the discussions, the state would have until September 1, 2017 to transition to other funding mechanisms without risk of disallowance on the same grounds as the 2014 deferral.[9]

Over the following months, HHSC provided CMS with substantial documentation and information in support of the questioned private hospital funding arrangements. Discussions concluded in September 2015, at which time HHSC anticipated receiving from CMS an evaluation of the allowability of the funding model used in Dallas and Tarrant Counties. That did not happen. Prior to the disallowance being issued on September 1, 2016, HHSC never received notice from CMS that a final determination had been made.

II. Request for Reconsideration

HHSC requests reconsideration of the disallowance on multiple grounds. The following explanations demonstrate that the disallowance was incorrectly rendered.

A. HHSC acted in reliance on CMS' previous assurances.

By issuing the disallowance, CMS is acting contrary to two specific statements made by CMS to the state. First, in its letter to HHSC releasing the 2014 deferral, CMS stated that "to the extent CMS determines that any financing structure within Texas' Medicaid program violates federal statute and regulation, we would expect Texas to make necessary adjustments by December 2015."[10] CMS did *not* subsequently notify HHSC that it had determined that the financing

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[8] *See* Letter from Timothy Hill to Kay Ghahremani, Director, HHSC, (Jan. 7, 2015)(Exhibit 6).
[9] *See* Email from Tim Hill to Monica Leo Re: Private Hospital funding -- confirmation of transition schedule (June 9, 2015)(Exhibit 7).
[10] *See* Exhibit 6.

structure in Dallas and Tarrant Counties violates federal statute and regulation. CMS then disallowed federal matching funds for expenditures made before December 2015.

More importantly, CMS agreed that Texas would have until September 1, 2017 to make changes to the funding arrangements, if required following the discussions between CMS and HHSC during the summer of 2015.[11] CMS confirmed to HHSC that current funding arrangements would be allowed to continue for payments through August 2017, without risk of disallowance on the same grounds questioned in the 2014 deferral.[12]

CMS' agreement to provide time for transitioning to other funding models was reasonable and recognized several important facts and considerations:

- Private hospital participation in providing care to the Medicaid and uninsured populations is critical to the healthcare safety net in Texas;
- Unplanned disruptions to the safety net jeopardize the ability of these vulnerable populations to access needed care;
- The current funding arrangements have been in place across Texas since 2005 and in Dallas and Tarrant Counties since March 2007 and May 2009 respectively, with the knowledge and approval of CMS;
- Unwinding the long-standing funding mechanisms, including the public process for local governmental entities to revise or adopt budgets, takes time;
- Identifying and implementing alternative funding sources for private hospital payments may require state legislative action;
- The Texas legislature meets every two years and is not scheduled to be in session again until January 2017;
- Notice and comment rulemaking by HHSC may be necessary to implement legislative directives.

Following the conclusion of the discussions during the summer of 2015, HHSC believed that CMS would notify HHSC of its final determination after reviewing all of the information and documentation provided to CMS by the state.[13] CMS never notified HHSC of a final decision on the funding arrangements. HHSC and hospital stakeholders acted in good faith in response to the financial review of private hospital payments, the deferral, and the series of discussions during the summer of 2015. In reliance on CMS' written assurances that payments were not at risk of disallowance, HHSC continued making payments to private hospitals while waiting for a decision from CMS.

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[11] *See* Exhibit 7.
[12] *Id.*
[13] *See, e.g.,* Email from Kristin Fan, CMS, to Monica Leo Re: Private Hospital funding -- topics for discussion (September 15, 2015)(Exhibit 8)("We have received all of the information and I don't think we have any other questions that need to be answered. We are working with our leadership to discuss next steps").

In making the the UC payments now at issue, HHSC acted in reliance on multiple CMS statements. However, CMS (1) disallowed federal funds they previously stated were not at risk; and (2) did not live up to the terms of the agreement extending until September 1, 2017, the date for Texas to make changes to private hospital funding arrangements. In order to effectively run such a large and complicated program as Medicaid, HHSC must be able to rely on CMS' statements. HHSC asks that CMS withdraw the disallowance and adhere to its agreement to allow current funding relationships to continue through at least September 1, 2017.

B. There is no donation to a governmental entity.

The Dallas County arrangement was the subject of scrutiny by CMS in 2007 and 2008 during the deferral of Texas' Private Hospital 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. In response to the deferral, HHSC provided to CMS full disclosures of the factual and legal support for the financing of the non-federal share of UPL payments to private hospitals.[14] During the subsequent discussions between CMS and HHSC, HHSC agreed to pay back $37.6 million in federal financial participation ($22.9 million of which related to the Dallas market and all of which appeared to relate to a retroactive feature of the prior arrangement) and to keep $122.6 million that CMS initially questioned in the deferrals. As part of the overall resolution of the deferrals, HHSC also worked with CMS to develop the proposed Conditions of Participation for continuing the UPL program for private hospitals.[15] CMS' review and subsequent lifting of the deferral, with full knowledge of how the program worked, constituted recognition that the Dallas County arrangement complied with federal law. The Tarrant County Indigent Care Affiliation Agreement was first effective in May 2009 and the arrangement was structured consistent with the Dallas County model and the Conditions of Participation.

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 the disallowance 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.[16]

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[14] *See* Exhibit 4.
[15] *See* Letter from HHSC to James Frizzera, Director, CMS Financial Management Group and Conditions of Participation attached thereto (May 1, 2008)(Exhibit 9).
[16] 42 U.S.C. § 1396b(w)(2)(A) (2014); 42 C.F.R.§ 433.52 (2014).

Under the Dallas County 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. CMS does state in the preamble to its 2007 cost rules (ultimately vacated for other reasons), that one issue in assessing compliance with provider donation regulations was whether a private hospital provides services that are the legal obligation of a governmental entity.[17] However, the private hospitals at issue are not assuming any legal obligation of the governmental entity. In Texas, hospital districts and counties are generally required to provide or pay for indigent care *only as a payer of last resort.*[18] As HHSC stated during discussions concerning the 2007 deferral, "[t]he scope of the local government entity's obligation is...to provide or pay for indigent care that someone else is not providing or paying for."[19]

Further, 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. The only way to characterize the Dallas County model as resulting in a provider donation is if the prior provision of or payment for care by the public entity in and of itself creates an ongoing legal obligation for the government to continue to provide or pay for these services in perpetuity. When private entities provide or pay for services in the community at their sole discretion, some of which may have previously been provided or paid for by a governmental entity, there is no donation. The mere expectations and historical practices of the private and the governmental entities do not somehow transpose the provision or payment 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 and 2008. One of the documents provided to CMS was a memorandum describing the Dallas County model.[20] Another document submitted to CMS in 2008 was a letter explaining why there is no assumption of obligations of the local governmental entity.[21] 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.

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[17] *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 transferred by the local government to a state as the non-Federal share of Medicaid payments.").

[18] Tex. Health and Safety Code §§ 61.022(b) and 61.060(c).

[19] Exhibit 4 at 3.

[20] *See* Memorandum dated August 21, 2007, to James Frizzera, CMS, and Daniel Aibel, HHS Office of General Counsel (Exhibit 10).

[21] *See* Exhibit 4, explaining, among other things, that it was initially contemplated that the Dallas County Hospital District would assign the physician contract to the affiliated private hospitals, but that the arrangement was revised effective March 31, 2007, to provide for termination of the contract between the hospital district and the physician group, thus terminating any contractual obligation on the part of the hospital district with regard to those physician services.

The Tarrant County arrangement was not in existence at the time of the Private Hospital UPL program deferral, but was and is structured consistent with the Dallas County model and the Conditions of Participation.

C. Even if CMS finds that there is a donation, no hold harmless practices exists.

If CMS were able to successfully argue a provider-related donation exists, that determination is not the end of the analysis. It is possible for a provider-related donation to be permissible under federal law so long as the donation has no direct or indirect relationship to Medicaid payments.[22] A direct or indirect relationship is found where there is a hold harmless provision or practice.[23]

In turn, a hold harmless provision or practice exists if:

(1) The state (or other unit of government) provides for a direct or indirect non-Medicaid payment to those providers or others making, or responsible for, the donation, and the payment amount is positively correlated to the donation. A positive correlation includes any positive relationship between these variables, even if not consistent over time;
(2) All or any portion of the Medicaid payment to the donor, provider class, or related entity, varies based only on the amount of the donation, including where Medicaid payment is conditional on receipt of the donation; or
(3) The State (or other unit of local government) receiving the donation provides for any direct or indirect payment, offset, or waiver such that provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation).[24]

First, HHSC is unaware of any non-Medicaid payment to private hospitals that is positively correlated to the alleged donation. Second, the determination of the Medicaid payment to the private hospitals at issue is independent of amount of the alleged donation. Last, the local governments that IGT on behalf of private hospitals in no way (directly or indirectly) guarantee a return of the alleged donation. In fact, the Conditions of Participation that remain in effect require the participants in the UC program to ensure, among other things, that no such guarantee exists.[25]

Not only did CMS' notice of disallowance fail to identify a provider-related donation, CMS also failed to identify any practices that violate the hold harmless provision. Since CMS has not shown that a hold harmless exists, as defined by federal regulation, there is no basis for the disallowance.

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[22] 42 CFR 433.54(a).
[23] 42 CFR 433.54(b).
[24] 42 CFR 433.54(c).
[25] *See* Certification of Hospital Participation (Exhibit 11) and Certification of Governmental Entity Participation for Hospital Affiliates (Exhibit 12).

D. CMS cannot base its disallowance on SMDL #14-004.

In the September 1, 2016, disallowance letter, CMS states that the private hospital funding arrangement in Texas "constitutes a non-bona fide donation as described in the May 9, 2014 [SMDL #14-004]." HHSC does not agree that the arrangements in Dallas and Tarrant Counties necessarily coincide with the fact situation described in SMDL #14-004. To the extent that CMS relies on the letter for the disallowance, such reliance is misplaced because the letter articulates a policy that is inconsistent with CMS' established practice, regulations and CMS prior approval of the Texas funding arrangements and can therefore be implemented only after notice and comment rulemaking. The Dallas and Tarrant County funding arrangements remain compliant with the multiple disclosures to CMS as well as the Conditions of Participation; the only thing that has changed since the prior CMS approvals is SMDL #14-004.

1. SMDL #14-004 is ambiguous at best.

SMDL #14-004 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 (please see the section above for the regulatory description of a hold harmless). However, in focusing on the existence of a hold harmless provision or practice, the SMDL is assuming the existence of a provider-related donation. As discussed above, HHSC does not believe that the funding arrangement in question results in a provider-related donation as defined in the statute and regulations, and thus the hold harmless analysis is unnecessary.

Regardless of the existence of a donation, to HHSC's knowledge, there are no agreements between parties that violate the existing regulations or CMS' prior approvals. 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).

HHSC believes that SMDL #14-004 can be fairly read to allow the Dallas County arrangement, 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.

CMS has not provided evidence of an agreement between Dallas and Tarrant County hospital districts and private hospitals that contradicts the regulations or CMS's prior approvals. For this reason, HHSC urges CMS to withdraw the disallowance.

2. CMS previously approved the Dallas funding arrangement under the current, unchanged regulatory requirements.

If CMS still believes that SMDL #14-004 precludes the Dallas and Tarrant County arrangements, it nonetheless may not rely on the letter to support the disallowance.

In 2006, CMS approved the private-hospital UPL state plan amendment after being fully informed and provided with sample contracts showing that private hospitals would provide indigent services that could result in extra funds available to local governmental entities that could be used to fund the Medicaid program. In 2008, CMS lifted the private hospital UPL deferral with knowledge of the funding arrangements in Dallas County and elsewhere. In 2012, CMS approved payments to private hospitals under the UC program knowing that they are funded using the same funding mechanisms as were used under the former UPL program and under the same Conditions of Participation. In other words, for more than 11 years—consistent with the Social Security Act and federal regulations—CMS has knowingly approved and allowed the arrangement in Dallas County to continue. SMDL #14-004 marks a departure from the provisions set forth in Section 1903(w) of the Social Security Act, CMS' existing regulations regarding provider-related donations, and CMS' prior approvals of the Texas program.

CMS must give states and providers an opportunity for notice and comment before disallowing federal funds on the basis of the new policies announced in SMDL #14-004.[26]

E. CMS erred in the disallowance calculation.

To calculate the amount of the purported donation, CMS used the estimated annual charity care services budget for the non-profit organizations totaling $188 million. Then CMS calculated a quarterly amount ($47 million) as a proxy for the non-bona fide provider-related donation. CMS then deducted the amount of the federal share from the quarterly donation estimate to identify a disallowance of $26.8 million.

CMS did not verify whether the services paid for or provided by the non-profits in the quarter totaled $47 million. Even assuming, and without conceding, that the payments for physician and other professional healthcare services were non-bona fide provider-related donations to the hospital districts, CMS should have calculated the amount of the disallowance using actual expenditures, as follows:

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[26] *See, e.g., Shell Offshore Inc. v. Babbitt, et al.*, 238 F.3d 622 (5th Cir. 2001)(requiring notice-and-comment rulemaking where the challenged agency action was the result of a departure from the agency's previous practice); *see also Ohio Dept. of Human Servs. v. U.S. Dept. of Health & Human Servs.*, 862 F.2d 1228, 1231 (6th Cir. 1988)(invalidating rule amendment that was not implicit in the original regulation; was inconsistent with prior actions of the agency; and was not adopted in compliance with notice-and-comment requirements).

Organization #1: expenditure on services in 4Q 2015[27]	$34,742,206
Organization #2: expenditure on services in 4Q 2015	$ 9,500,952
Total Purported Non-Bona Fide Provider-Related Donation	$44,489,015
Applicable FMAP at time of claimed expenditure:	57.13%
Amount of Disallowance	$25,276,116
CMS Calculated Disallowance	$26,844,551
Overstated Disallowance	$ 1,568,435

By using a proxy of the charity care services the non-profits estimated they would provide during the fiscal year as the basis to identify the purported non-bona fide provider-related donation in the quarter, CMS overstated the disallowance by $1.57 million.

Additionally, CMS' proxy methodology yields absurd results, therefore showing serious flaws in the underlying reasoning. The methodology, if applied on an annual basis, would result in a total purported donation of approximately $187 million. That exceeds the annual intergovernmental transfers from the hospital districts (together, $114 million) by $73 million.

III. State's Intent to Retain Funds

The state wishes to retain the disallowed funds pursuant to 42 C.F.R. § 433.48(c)(2).

IV. Conclusion

For all of the reasons explained in this letter, HHSC asks CMS to reconsider and withdraw the September 1, 2016, disallowance of federal funds. Please let me know if you have any questions or need additional information. Charlie Greenberg, Director of Policy for HHSC Legal Services, is serving as the lead staff on this matter and can be reached at (512) 424-6863 or by e-mail at Charles.Greenberg@hhsc.state.tx.us.

[27] This refers to the fourth quarter of the organization's 2015 fiscal year, which coincides with the first quarter of the 2016 federal fiscal year that is the period for which HHSC expenditures are being disallowed.

Sincerely,

Jami Snyder
Associate Commissioner for Medicaid/CHIP Services

Enclosures

cc: Dorothy Ferguson, CMS
Jeoffrey Branch, CMS

EXHIBIT 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID
& CHILDREN'S HEALTH OPERATIONS

Division of Medicaid & Children's Health, Region VI

September 1, 2016

DISALLOWANCE TX/2016/001/MAP

Ms. Jami Snyder
State Medicaid Director
Associate Commissioner for Medicaid / CHIP
Texas Health and Human Services Commission
P.O. Box 13247
Mail Code: H100
Austin, Texas 78711

Dear Ms. Snyder:

This letter is notice of a disallowance in the amount of $26,844,551[i] Federal Financial Participation (FFP), as reported on the CMS-64 quarter ending December 31, 2015. The disallowance amount is based on the projected value of in-kind donations to the Dallas and Tarrant County hospital districts by the Dallas County Indigent Care Corporation (DCICC) and the Tarrant County Indigent Care Corporation (TCICC), which are both funded by local private hospitals. The Counties' related Intergovernmental Transfers (IGTs) to the State, to fund Uncompensated Care Pool (UC) payments to participating private hospitals, were principally derived from county funds augmented by these donations and formed a hold harmless arrangement in violation of the Medicaid Statute and regulations.

Section 1903(w) of the Social Security Act (the Act) generally places limitations on the use of provider-related donations and taxes as funding sources for expenditures claimed by states as the basis for FFP. Among these limitations, as set forth in implementing regulations at 42 C.F.R. § 433.54, FFP is not available to the extent that it would be based on the use of such financing sources when there is a "hold harmless arrangement" under which providers (or the provider class) could be effectively repaid for a provider-related tax or donation through any direct or indirect payment, offset, or waiver. A hold harmless arrangement is defined to include circumstances in which an increased Medicaid payment is conditional on the receipt of a donation.

CMS issued State Medicaid Director Letter (SMDL) 14-004 to all states on May 9, 2014 regarding the allowable and unallowable use of provider-related donations, including the related use of certain types of public-private arrangements. This letter discusses situations where governmental entities and private entities enter into agreements or relationships that constitute non-bona fide provider-related donations, in which private entities provide a governmental entity with funds or other consideration and receive in return additional Medicaid payments. Under

these circumstances, there is a hold harmless arrangement in which the contract to provide services is a provider-related donation and the receipt of additional payments is the return of some, or all, of the donation. The letter specified that this type of arrangement is a non-bona fide donation prohibited by statute and regulations.

CMS has identified a similar arrangement in Texas among various local governments, private hospitals, and non-profit organizations that constitutes a non-bona fide donations as described in the May 9, 2014 guidance. In this arrangement, a group of private hospitals indirectly assumed financial responsibilities once held by the local governments and, in exchange, received payments under the Medicaid program. Specifically, the Counties and private hospitals coordinated to create the DCICC and TCICC to fund contracts previously held by the local governments that provide faculty staff within the Counties' medical facilities. The donated services augmented Dallas and Tarrant Counties' funds and the Counties then transferred funds to the state Medicaid agency via IGT. The Medicaid agency used funds derived from the donation-based IGTs, as the non-federal share to draw FFP, and made additional Medicaid payments under the State Plan, and or a section 1115 demonstration waiver, to the same private hospitals that fund TCICC and DCICC. See, Act, Section 1903(w)(6)(A).

Section 1903(w)(1)(A) of the Act and implementing regulations at 42 CFR 433.67(b) require that CMS deduct from a state's quarterly medical assistance expenditures any non-bona fide, provider-related donations received in that quarter by the state or a local unit of government. Accordingly, this letter constitutes your notice of disallowance in the amount $26,844,551 FFP. Please make a decreasing adjustment on line 10(c) of the next quarterly expenditure report (CMS-64) in the amount of $26,844,551 FFP for FY2016 and reference TX/2016/001/MAP.

This disallowance is my final decision. Under section 1116(e) of the Social Security Act, the state has the opportunity either to request reconsideration of this disallowance from the Secretary or to appeal this disallowance to the Departmental Appeals Board. This decision shall be the final decision of the Department unless, within 60 calendar days after the State receives this decision, the State delivers or mails (the state should use registered or certified mail to establish the date) a written request of reconsideration to the Secretary or a written notice of appeal to the Departmental Appeals Board.

Written requests for reconsideration should be delivered or mailed to the CMS Associate Regional Administrator at 1301 Young St. Suite 832, Dallas TX 75202 (the state should use registered or certified mail to establish the date). Requests for reconsideration by the Secretary should include: (1) A copy of the disallowance letter; (2) A statement of the amount in dispute; (3) A brief statement of why the disallowance should be reversed or revised, including any information to support the state's position with respect to each issue; (4) additional information regarding factual matters or policy considerations; and (5) a statement of your intent to return or retain the funds. See 42 C.F.R. § 430.42(b)(2) published at 77 Fed. Reg. 31499, 31508 (May 29, 2012). The state should include in its request for reconsideration all of the information it believes is necessary for the Secretary's review of its request. If the State requests reconsideration from the Secretary and receives an unfavorable reconsideration of the disallowance from the Secretary, it may appeal the disallowance to the Departmental Appeals Board within 60 calendar days after the date that the State receives the unfavorable reconsideration. Written requests for appeal should be delivered or mailed to:

U.S. Dept. of Health and Human Services
Departmental Appeals Board, MS 6127
Appellate Division
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

The state may appeal the disallowance to the DAB within 60 calendar days of the date you received this letter or, if applicable, within 60 calendar days after the date that the State receives the unfavorable reconsideration. If the state chooses to appeal this disallowance, written appeals request must include: (1) a copy of this disallowance decision; (2) a copy of the reconsideration decision, if applicable; (3) a note of its intention to appeal the disallowance; (4) the amount in dispute; and (5) a brief statement of why the disallowance is wrong. In addition, the state should reference Disallowance Number TX/2016/001/MAP in the appeal request. The Board will notify the state of further procedures. Please also send a copy of your appeal to my attention at the following address Mr. Bill Brooks, Associate Regional Administrator; Centers for Medicare & Medicaid Services, Region 6; 1301 Young Street, Room 833; Dallas, Texas 75202.

A notice of appeal may also be submitted to the DAB by mail, by facsimile (fax) if under 10 pages, or electronically using the DAB's electronic filing system (DAB E-File). Submissions are considered made on the date they are postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully submitted via DAB E-File. To use DAB E-File to submit your notice of appeal, you or your representative must first become a registered user by clicking "Register" at the bottom of the DAB E-File homepage, https://dab/efile.hhs.gov/; entering the information requested on the "Register New Account" form; and clicking the "Register Account" button. Once registered, you or your representative should login to DAB E-File using the e-mail address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions can be found on the DAB E-File homepage.

If the State appeals the disallowance under section 1116(d) of the Act, section 1903(d) of the Act provides you the option of retaining the funds that was previously paid to the State and that is now being disallowed by this notice, pending a final administrative decision. If the final decision upholds the disallowance and you elect to retain the funds during the appeals process, the proper amount of the disallowance plus interest computed pursuant to section 1903(d)(5) of the Act will be offset in a subsequent grant award.

You may exercise your option to retain the disputed funds by notifying me, in writing, no later than 60 days after the date this letter is received. In the absence of notification that the State elects to retain the funds, the Secretary will recover $26,844,551 FFP pending the final decision of the Departmental Appeals Board.

If you have any questions, please contact Dorothy Ferguson at 214-767-6385 or Jeoffrey Branch at 214-767-6449 or their respective email addresses are Dorothy.ferguson@cms.hhs.gov or Jeoffrey.branch@cms.hhs.gov.

Sincerely,

Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health

cc via Email: Monica Leo / HHSC
Charles Greenberg / HHSC

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[i] The basis of the disallowance is the estimated quarterly value of various contracts by DCICC and TCICC and then multiplying that amount by the appropriate FFP @ 57.13% for FFY2016.

Non Profit Entity	Est Value of Contract(s) Donation Amount	Quarterly Equivilent of Donation	FFP at Risk (57.13%)
DCICC	$142,646,144	$ 35,661,536	$ 20,373,436
TCICC	$ 45,308,000	$ 11,327,000	$ 6,471,115
Total	$187,954,144	$ 46,988,536	**$ 26,844,551**

EXHIBIT 2

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

June 30, 2006

Mr. Andrew A. Fredrickson
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services
1301 Young Street, Room 827
Dallas, Texas 75202

Dear Mr. Fredrickson,

This is our response to your letter dated March 21, 2006, in which questions were raised regarding the proposed amendment to the Texas Medicaid State Plan submitted by the Health and Human Services Commission (HHSC) under Transmittal Number 05-011.

The Centers for Medicare and Medicaid Services (CMS) requested that HHSC provide the following additional or clarifying information before CMS could continue processing the amendment. The questions from CMS are included and followed by HHSC's responses in bold.

1. Pending TN 05-001. Proposed language in TN 05-011 modifies language that is pending in TN 05-001. Therefore, all of the questions and concerns in our request for additional information for TN 05-001 must be addressed before favorable action can be taken on TN 05-011. Further, TN 05-011 should be revised to reflect any changes made to TN 05-001. Please note that since TN 05-011 further expands the use of supplemental payments funded through transfers for local entities, it is imperative to provide all of the information requested for TN 05-001 regarding the Upper Payment Limits (UPL) demonstrations and provider taxes. Please note that information relating to provider taxes requested in TN 05-001 was "district" specific. For every additional district added under TN 05-011, the State must provide the requested "district" specific information.

   You have requested that all of the information requested for TN 05-001 regarding the UPL demonstrations and provider taxes be provided for TN 05-011 as well. As to the UPL demonstrations for TN 05-011, please refer to Question 13 for a detailed demonstration of the State-owned or operated hospital UPL, the non-State government hospital UPL, and the private hospital UPL for inpatient hospital

services. These demonstrations provide the same analysis of the aggregate upper payment limitations that the State provided in response to the request for additional information (RAI) for TN 05-001. In addition, Question 18 provides a description of the methodology used by the State to ensure that outpatient UPL payments do not exceed the outpatient upper payment limitations.

As to provider taxes, none of the regions implementing Medicaid supplemental payment programs pursuant to TN 05-011 (i.e., regions in which hospitals have an indigent care affiliation agreement with a hospital district or other local government entity) will utilize provider tax revenue to fund the non-Federal share of Medicaid supplemental payments. The Texas Legislature did not create Healthcare Funding Districts for any counties outside of Webb, Hidalgo, and Bexar, which were all addressed in our responses to the RAI for TN 05-001. All of the regions that are implementing Medicaid UPL programs pursuant to TN 05-011 will utilize local ad valorem tax revenue from a pre-existing local governmental entity, either a county or a hospital district, to transfer to the State as the non-federal share of the Medicaid funding the hospitals in that region are eligible to receive.

In addition, attached is Exhibit A, a spreadsheet entitled "Hospital Summary Worksheet," similar to the Hospital Summary Worksheet that the State provided in its responses to the RAI for TN 05-001, which includes data on the entities responsible for transferring funds, the amount of the transfers, and the amount of regular Medicaid and supplemental payments. The State used the most recently available data sources applicable to the current state fiscal year to calculate the amounts in the "Hospital Summary Worksheet."

2. Public Notice. Section 1902(a)(13)(A) of the Social Security Act and regulations at 42 CFR 447.205 require that public notice be given prior to the effective date of a change in reimbursement rates. Please provide a copy of the public notice issued regarding the proposed changes in TN 05-011.

HHSC announces its intent to submit to the Centers for Medicare and Medicaid Services an amendment to the Texas State Plan for Medical Assistance under Title XIX of the Social Security Act.

The amendment provides for UPL supplemental reimbursement for Medicaid inpatient and outpatient hospital services provided by privately owned hospitals with an indigent care affiliation agreement with a hospital district or other local government entity. The supplemental payments shall not exceed the difference between total annual Medicaid payments and the Federal UPL established in

42 CFR § 447.272. As a result, the State seeks to ensure that Medicaid payments to private hospitals are commensurate with Medicare payments and/or payment principles.

The proposed amendment is to be effective November 12, 2005, and is expected to increase the amount of federal matching to the State. The proposed amendment is estimated to result in increased annual expenditures of $426,413,000 with increased federal matching funds of $258,662,000 for state fiscal year 2006, and $503,931,000 with increased federal matching funds of $304,977,000 for State Fiscal Year 2007.

3. Fiscal Impact. Please provide a breakdown of the fiscal impact reported on the 179 form to indicate the amount attributable to changes in inpatient services and the amount attributable to outpatient services. Please explain how the fiscal impact was estimated.

Please refer to Exhibit B, which sets out the estimated inpatient and outpatient hospital supplemental funding that would be generated by the approval of this State Plan Amendment.

Following is the breakdown of the estimated fiscal impact for inpatient and outpatient hospital services under TX 05-011:

Fiscal Year	Total Fiscal Impact	Non-Federal Share	Federal Share
FY 2006	*$ 426,413,000*	*$167,751,000*	***$ 258,662,000***
FY 2007	*$ 503,931,000*	*$ 198,954,000*	***$ 304,977,000***
Fiscal Year	***Inpatient Fiscal Impact***	***Non-Federal Share***	*Federal Share*
FY 2006	*$ 423,974,508*	*$ 166,791,571*	***$ 257,182,936***
FY 2007	*$ 500,980,549*	*$ 197,085,748*	***$ 303,894,801***
Fiscal Year	***Outpatient Fiscal Impact***	***Non-Federal Share***	*Federal Share*
FY 2006	*$2,438,209*	*$ 959,191*	***$ 1,479,018***
FY 2007	*$ 2,950,163*	*$ 1,160,594*	***$ 1,789,569***

The fiscal impact for TX 05-011 is estimated based on the applicable Medicaid UPL cap for each participating hospital using Medicaid fee for service results for state fiscal year ("SFY") 2005 and Medicaid disproportionate share hospital ("Medicaid DSH") preliminary data for SFY 2006.

4. Attachment 4.19-A, Page 10, (t)(4) & Attachment 4.19-B, Page 2aa, (8)(b) and (c). What is an indigent care agreement? Does this agreement require any transfer of funds between the hospital and the hospital district\local government? If so, please explain the requirement and describe both the amount and timing of the transfer. Is this a new type of agreement or are there existing agreements in place? Is there a standard agreement for all hospitals or does it vary between each district\local government? If there is a standard agreement, please provide a copy of the standard agreement. If each agreement is unique, please provide a copy of each agreement. What process does HHSC have in place to ensure there are no transfers of funds from the provider to the district/local government? Please note any transfer of funds would be an impermissible provider-related donation. CMS cannot approve TN 05-011 without absolute assurance that providers are retaining 100% of Medicaid payments.

What is an indigent care agreement?

Texas has available public funds that are dedicated to healthcare needs in the form of ad valorem tax revenues assessed at the local levels by Counties and Hospital Districts ("Local Taxing Entities"). Only a small portion of these tax revenues are currently being utilized to fund the Medicaid program through Medicaid disproportionate share hospital and current UPL program supplemental payments. Due to reductions in Medicaid spending and a growing Medicaid and uninsured population ("indigent"), there is a growing gap between the costs hospitals incur for treating indigent patients and the reimbursement they receive. In light of the growing gap between the cost of care and reimbursement, the Local Taxing Entity in certain Texas communities 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.

An indigent care agreement is the agreement between the Local Taxing Entity and a group of local private hospitals ("Affiliated 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. Examples of the types of indigent care services the Affiliated Hospitals may provide include inpatient and outpatient hospital services, specialty physician services, pharmaceutical services, kidney dialysis, dentistry, nursing hotline services, air ambulance services, emergency and on-call physician services, and ophthalmology.

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

tax revenue dedicated to healthcare needs to fund the Medicaid program, either by making an intergovernmental transfer of the tax revenue to the State as the non-Federal share of the Medicaid supplemental payment program or by making a supplemental payment directly to the Affiliated Hospitals based on each hospital's available Medicaid UPL room.

Does this agreement require any transfer of funds between the hospital and the hospital district\local government? If so please explain the requirement and describe both the amount and timing of the transfer.

The indigent care agreements do not require any transfer of funds between the Affiliated Hospitals and the Local Taxing Entity.

Is this a new type of agreement or are there existing agreements in place?

The first of these types of agreements were entered into in connection with the Medicaid supplemental payment program authorized by Texas Medicaid State Plan Amendment 05-001. There are now several existing agreements in place and others are in the process of being negotiated.

Is there a standard agreement for all hospitals or does it vary between each district\local government? If there is a standard agreement, please provide a copy of the standard agreement. If each agreement is unique, please provide a copy of each agreement.

The indigent care agreements are substantially identical, but do vary slightly between each region depending upon the individual needs and resources of the community and the constitutional framework of the particular Local Taxing Entity. At your request, the State is attaching a copy of the indigent care agreement (either already fully executed or expected to be fully executed) for every region that currently plans to operate a Medicaid supplemental payment program pursuant to the authorization of Texas Medicaid State Plan Amendments 05-001 and 05-011 ("Locally Funded Medicaid Program"). To the extent any additional regions want to implement a Locally Funded Medicaid Program utilizing an indigent care agreement that is not substantially similar to the agreements included with this response, the State will supplement this response with those indigent care agreements.

What process does HHSC have in place to ensure there are no transfers of funds from the provider to the district/local government?

In order to ensure that providers will not transfer or return any portion of hospital funds or the supplemental Medicaid payments they receive to the local government funding source, the State is requiring each hospital to independently certify that it will not transfer or return any funds to the local government entity that provides the non-federal share. The State is also requiring the local government entities to execute similar forms certifying that they will not receive any funds from the private hospitals participating in these programs. A copy of the certification forms the State intends to use for this purpose is enclosed for your review (Exhibits C and D).

5. Attachment 4.19-A, Page 10a, (t)(4)(A). Language limiting the supplemental payment to the lesser of the room available under the DSH limit or billed charges has been removed. Was this intentional? This would set reimbursement to 100% of billed charges. Please explain how this would be consistent with efficiency, economy, and quality of care when no major payer of services, including Medicare, pays at 100% of billed charges. Further, billed charges may not be used as the basis for determining the UPL, and in our experience almost always exceed the UPL.

The limitations on supplemental payments in paragraphs (t)(3), (t)(4) and (t)(5) of Attachment 4.19-A are intended to, and do, comply with the Federal regulations at 42 C.F.R. § 447.271 (the Medicaid UPL cap) and the Federal regulations relating to the cap on individual hospitals codified at 42 C.F.R. § 447.272(c)(2) (limitations on Disproportionate Share Hospitals). It is not the intention of the State to set reimbursement at 100 percent of billed charges. Rather, it is the intention of the State to assure CMS that the State will limit Medicaid reimbursement to the cap applicable to each individual hospital. Specifically, hospitals that qualify for Medicaid DSH funding will be limited to Medicaid reimbursement at the lower of their Medicaid UPL cap or their Medicaid DSH cap. Because the Medicaid DSH rules do not apply to hospitals that do not receive Medicaid DSH reimbursement, hospitals that do not qualify for Medicaid DSH funding will be limited in the amount of Medicaid reimbursement they receive to their Medicaid UPL cap.

The State modified the language of paragraph (t)(4)(A) to highlight to CMS that the State is aware of the different limitations Federal law places on individual hospital reimbursement and to assure CMS that the State will not pay any individual hospital more than the limitation(s) imposed on that hospital by Federal law. The language of paragraph (t)(3) still applies to all supplemental payments authorized under paragraph (t). Paragraph (t)(3)(A) prevents the State from paying any hospital that receives Medicaid DSH funding an amount greater than that hospital's "hospital specific limit" by stating that "in each State Fiscal Year the amount of any inpatient supplemental payments and outpatient supplemental payments may not

exceed the hospital's "hospital specific limit," as determined under Appendix I to Attachment 4.19-A for DSH hospitals" (emphasis added). The State removed the language in section (t)(4)(A) to make it clear that the State intends to continue to apply the hospital specific limit, as defined in section 1923(g) of the Act, to Medicaid DSH hospitals unless that hospital's "hospital specific limit" is higher than its Medicaid UPL cap, in which case the Medicaid UPL cap will be applied. Consistent with 42 C.F.R. § 447.271, however, Texas will only apply the Medicaid UPL cap to hospitals that do not receive Medicaid DSH payments.

6. Attachment 4.19-A, Page 10a, (u). If payments are being made up to 100% of the UPL under section (t), please explain how high volume Medicaid payments can continue to be made without exceeding the UPL.

Texas makes several forms of Medicaid payments for inpatient hospital services under Attachment 4.19-A. First, Texas makes fee-for-service payments for inpatient Medicaid services at hospitals. Second, to the extent of the hospital specific limit, as calculated pursuant to Federal and State law, Texas provides Medicaid disproportionate share hospital ("Medicaid DSH") funding to hospitals that (1) qualify for the Medicaid DSH program and (2) have a positive hospital specific limit using the methodology described in Appendix 1 and the response to question 4 of the RAI dated September 23, 2005. However, Medicaid DSH funding is limited to approximately $800 million to $1.1 billion each fiscal year for non State-owned hospitals (public and private) and does not reimburse most participating hospitals' full unreimbursed costs for treating Medicaid and uninsured patients.

Private urban hospitals that participate in the Medicaid DSH program are eligible to participate in a high-volume Medicaid supplemental payment program totaling $26.4 million, pursuant to section (u) of Attachment 4.19-A. Hospitals receiving funds from the section (u) high-volume Medicaid provider program are limited in the amount they may receive by their unreimbursed hospital specific limit, after deducting any Medicaid DSH funding they received. Supplemental payments under section (u) of Attachment 4.19-A are paid up to the lower of the applicable Medicaid UPL cap or the amount of funds available in the section (u) program. Texas recently amended the amount of funding and eligibility for participation in a high volume Medicaid provider program under section (u) of Attachment 4.19-A. As revised, no hospital is eligible to receive funding under section (u) unless it participates in the Medicaid DSH program and has unreimbursed costs of treating Medicaid and uninsured patients, as calculated in the Medicaid DSH program, after receipt of Medicaid DSH funding in the current State Fiscal Year.

Finally, for hospitals participating in a regional Medicaid supplemental payment program, section (t)(4) of Attachment 4.19-A will provide supplemental payments for their remaining unreimbursed costs of providing care to Medicaid and other patients (the methodology for determining the applicable Medicaid UPL cap is defined in response to question 4 of the RAI related to Texas State Plan Amendment 05-001). Consequently, in determining the amount of Medicaid supplemental payments payable in the new regional supplemental payment programs under section (t)(4) of Attachment 4.19-A, Texas first deducts any Medicaid supplemental payments paid or payable to participating hospitals under section (u) of Attachment 4.19-A in the current SFY. Texas deducts the amount of these section (u) payments from the applicable Medicaid UPL cap for each participating hospital and only makes payments under section (t) if, and to the extent, each participating hospital has a positive applicable Medicaid UPL cap. At no time will any hospital's combined payments received under sections (t) and (u) exceed its applicable Medicaid UPL cap.

The State makes supplemental payments using applicable Medicaid UPL caps from the prior State Fiscal Year. With the one-year delay between the determination of the applicable Medicaid UPL cap and the payment year, there is a possibility that a hospital could receive supplemental payments in excess of its applicable Medicaid UPL cap. The State has a reconciliation process to address such a disparity. To the extent that any interim supplemental payment exceeds a hospital's applicable Medicaid UPL cap during a year, the State would recoup any additional funds paid to that hospital in the reconciliation process following the close of the applicable State Fiscal Year and return to CMS the applicable Federal portion of any such recoupment.

7. Attachment 4.19-B, Page 2aa, (8)(d). The State indicates that quarterly supplemental payment is made for the difference between the hospital's Medicaid fee for service outpatient Medicaid payments received and 100% of Medicaid allowable outpatient hospital cost.

   - Does this mean cost and payment are not necessarily associated with the same dates of service?

No, cost and payment are associated with the same dates of service. As discussed in greater detail below, Medicaid outpatient hospital claims are reimbursed using an interim rate. For each Medicaid allowable outpatient hospital claim that is submitted to the State, the State calculates the Medicaid cost and then applies further cost reductions to derive a payment amount. Therefore, as cost is calculated and claims are paid on a claim-by-claim basis, the cost incurred and the Medicaid

payment received for each Medicaid outpatient hospital claim is associated with the same dates of service.

- How is Medicaid cost determined for purposes of this payment?

The State calculates the Medicaid allowable outpatient hospital cost using an interim rate for each hospital, which is derived from each hospital's most recent tentative HCFA Form 2552 cost report (cost report) settlement. The interim rate is applied to the hospital's allowable Medicaid charges to derive an interim payment amount for each claim. At this point the interim payment amounts represent 100 percent of Medicaid allowable outpatient hospital cost. The interim payment amounts are then reduced by either 18.02 percent or 22.20 percent, depending on the hospital's status as a high-volume Medicaid provider. A high-volume provider is defined as one that was paid at least $200,000 during calendar year 2000. The State also reduces all payments by 2.5 percent on all outpatient hospital claims. Cost is calculated and adjusted in this manner by the State at the time it pays each Medicaid outpatient hospital claim, and the reductions also apply to the final cost report settlement process.

For purposes of making the Medicaid supplemental payments described in Attachment 4.19-B, Page 2aa, Paragraph 8(d), the State compares 100 percent of Medicaid allowable outpatient hospital cost, as calculated according to the above described methodology, to the amount of outpatient Medicaid payments each hospital received during the same time period. Due to the cost reductions that are applied to each claim, the outpatient Medicaid payments each hospital receives are less than Medicaid allowable cost. The difference between Medicaid allowable cost and Medicaid payments received represents unreimbursed Medicaid outpatient cost. This unreimbursed outpatient cost is compared to the room under each hospital's applicable UPL cap, if any. The outpatient UPL reimbursement amount is the lesser of actual unreimbursed outpatient Medicaid cost or available applicable UPL cap room.

- Please compare cost as determined for this payment to the State's cost-based UPL calculation, indicating the similarities and differences.

In calculating the amount of the Medicaid supplemental payments described in Attachment 4.19-B, Page 2aa, Paragraph 8(d), cost is determined according to the above described methodology. The cost based UPL is calculated according to the same methodology. Each hospital is limited individually in the amount of supplemental payments it is eligible to receive by its unreimbursed outpatient cost.

By ensuring that no hospital is paid more than cost for outpatient hospital services in this manner, no payments are made that exceed the UPL.

- Is the scope of services, as reflected in the Medicaid outpatient charges and Medicaid payment the same for both the UPL and the supplemental payment?

Yes, the scope of services is the same. The State uses data from the same timeframe, including all of the same charges and payments, to calculate both the UPL and the supplemental payment amounts.

8. The State indicated that supplemental payment would be consistent with the UPL established at 42 CFR 447.272. CMS requests the State to confirm that for outpatient hospital services it will not make payments that exceed the UPL at 42 CFR 447.321.

The State confirms that for outpatient hospital services it will not make payments that exceed the UPL at 42 CFR 447.321. Section 447.321 defines the aggregate limitation on the amount of Medicaid reimbursement that hospitals within three defined classes (State government-owned, non-State government-owned, and privately-owned) may receive for outpatient hospital services. The hospitals within each class are prohibited from receiving more than "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles" in outpatient Medicaid payments. As discussed in greater detail in the State's response to Question 7 above, the State applies reductions to cost at the time it pays each Medicaid outpatient hospital claim. In addition to these cost reductions, the State continues to apply a 5.8 percent capital reduction and a 10 percent operating cost reduction to its determination of Medicaid cost that the Medicare program eliminated as part of the outpatient prospective payment system. As a result of these capital and operating cost reductions in the Medicaid cost settlement process, outpatient unreimbursed cost eligible for Medicaid supplemental reimbursement is less than outpatient cost eligible for Medicare reimbursement. Therefore, because each individual hospital is never paid more than Medicaid eligible cost in a Medicaid outpatient hospital payment, and Medicaid eligible outpatient cost is less than Medicare eligible outpatient cost, the State is able to ensure that it will not make payments that exceed the UPL at 42 CFR 447.321.

9. Clinical diagnostic laboratory services, which are part of outpatient hospital services, are subject to a separate UPL at 1903(i)(7) of the Act which provides that payment shall not be made "with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount

exceeds the amount that would be recognized under section 1833(h) for such tests performed for an individual enrolled under part B of title XVIII." Under the clinical diagnostic laboratory UPL Texas may not pay more on a per test basis than the fee schedule amount that Medicare would reimburse.

These services are not included in the outpatient claims that HHSC uses as a basis for computing supplemental payments.

Funding Questions – Attachment 4.19-A

Although some description of funding sources was included in part of the initial submission, the information appears to blend both Attachment 4.19-A and Attachment 4.19-B. In addition, the information provided was not comprehensive. For Attachment 4.19-A, please provide responses for all payments (DRG, DSH, GME, high volume, supplemental, etc) made under Attachment 4.19-A.

10. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Medicaid payments (including DRG, DSH, GME, high-volume, fee schedule, interim, supplemental or enhanced payments) are made directly to Medicaid providers. The State, local government, or any other intermediary organization does not retain any portion of the Medicaid payment.

In order to ensure that providers will not return any portion of supplemental Medicaid payments they receive to the local government funding source, we are requiring each hospital to independently certify that it will not return any of the supplemental payments it receives to the local government entity that provides the non-Federal share of its payments. We are also requiring the local government entities to execute similar forms certifying that they will not receive any portion of the supplemental Medicaid payments made to the hospitals under these programs.

A copy of the certification forms we plan to use are enclosed with these responses for your review (Exhibits C and D).

11. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the State share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the State share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the State to provide State share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-Federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the State agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

    (i) a complete list of the names of entities transferring or certifying funds;
    (ii) the operational nature of the entity (State, county, city, other);
    (iii) the total amounts transferred or certified by each entity;
    (iv) clarify whether the certifying or transferring entity has general taxing authority; and
    (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

The State share of funds used to draw down Federal funds for the Texas Medicaid FFS inpatient payments (DRG payments) and Medicaid Managed Care payments use general revenue.

The State share of funds used to draw down Federal funds for Texas Medicaid Supplemental Inpatient payments comes from intergovernmental transfers from public hospitals, hospital districts, or other public entities. The intergovernmental transfers are used to provide the State share of matching funds. The State and Federal funds are then used to reimburse non-State hospitals participating in the currently approved supplemental payment plans. The State's share of Medicaid supplemental payments made to large urban public hospitals and private hospitals pursuant to Attachment 4.19-A, paragraphs (t)(1) and (t)(4) of the Texas Medicaid State Plan, is provided using IGTs from local government entities. This process is effected through an Automated Clearing House Authorization Agreement for Automatic Withdrawals ("ACH Agreement") between the local governmental entity

and the Texas Comptroller's Office ("Comptroller"). Under the terms of the ACH Agreement, the local governments authorize the Comptroller to electronically withdraw funds from the local governmental account on a quarterly basis in order to fund the State's share of Medicaid supplemental payment programs.

HHSC calculates the amount of each local government's IGT based on available Medicaid UPL cap room for the hospitals receiving supplemental Medicaid reimbursement. HHSC then provides each local governmental entity's IGT amount to the Comptroller, and also provides notice, typically seven to ten days in advance, to the local governmental entity. Historically, the Comptroller has electronically withdrawn the local governmental funds pursuant to the ACH Agreement on a Monday, and supplemental Medicaid reimbursement payments are disbursed to eligible providers four days later. The amount of the local governmental IGTs under SPA 05-011 will be limited by the amount of available Medicaid UPL cap room.

The State share of funds used to draw down Federal funds for the Texas Medicaid Disproportionate Share Hospital program comes from intergovernmental transfers. The intergovernmental transfer for the non-State DSH program is provided by eight large urban non-State owned public hospital districts and one city hospital. The State and Federal funds are then used to reimburse non-State DSH providers. The intergovernmental transfer for the DSH program for State-owned hospitals is provided by State hospitals. The State uses funds appropriated to State-owned hospitals to draw down Federal funds. The State and Federal funds are then used to reimburse State-owned DSH hospitals.

	Urban	Rural	State-Owned
SFY 2005 Supplemental	$696,781,678	$68,067,668	$65,264,559
State Share	$272,650,671	$26,634,878	$25,538,021
SFY 2006 Supplemental	$651,270,819	$71,404,431	$65,264,559
State Share	$256,209,940	$28,090,503	$25,538,021

	DSH Payments	State Share
SFY 2005 DSH	$1,487,047,590	$580,599,178
SFY 2006 DSH	$1,512,677,798	$594,784,910

12. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Attachment 4.19-A Supplemental Payments

	Urban	Rural	State-Owned
SFY 2005 Supplemental	**$696,781,678**	**$68,067,668**	**$65,264,559**
State Share	**$272,650,671**	**$26,634,878**	**$25,538,021**
SFY 2006 Supplemental	**$651,270,819**	**$71,404,431**	**$65,264,559**
State Share	**$256,209,940**	**$28,090,503**	**$25,538,021**

13. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-State government owned or operated, and privately owned or operated).

A. Inpatient Aggregate Medicaid Upper Payment Limits

The methodology Texas uses to calculate the aggregate Medicaid upper payment limit for State-owned and operated hospitals, other government-owned and operated hospitals, and private hospitals is:

Medicare payments subject to case mix adjustment are divided by a hospital's Medicare case mix index (CMI) to determine total Medicare payments for a case mix of 1.0. Medicare pass-through payments are added, and the total is divided by Medicare discharges in order to determine a Medicare CMI-adjusted payment per discharge. Medicaid payments subject to case mix adjustment are divided by a hospital's Medicaid CMI to determine total Medicaid payments for a case mix of 1.0. Medicaid pass-through payments are added, and the total is divided by Medicaid discharges in order to determine a Medicaid CMI-adjusted payment per discharge. The Medicaid CMI-adjusted payment per discharge is subtracted from Medicare CMI-adjusted payment per discharge. The result is multiplied by the hospital's base year Medicaid CMI to determine a CMI-adjusted Medicaid Medicare payment per discharge differential. This payment per discharge differential is multiplied by Medicaid base year discharges and inflated to the current period. The calculation uses base year paid Medicaid claims and cost reports. All managed care patients are excluded from the calculation.

This methodology is consistent with Texas's current State Plan, which has been approved by CMS, paragraph (t)(2) of Attachment 4.19-A.

Texas's aggregate Medicaid UPL calculation methodology compares Medicaid reimbursement per discharge to Medicare payment per discharge for each aggregate hospital group. For both the Medicare and Medicaid portions of the calculation, the payment per discharge applies to hospitals that receive prospective payments. The payment per discharge is the result of dividing all payments received by the number of discharges. Payment types that are variable by individual patient acuity and therefore subject to case mix adjustment are first divided by the hospital's case mix index ("CMI"). Payments treated as pass-through payments are added without adjustment. The discrepancy between the two payment-per-discharge amounts, the "Medicare/Medicaid Differential," is then multiplied by the Medicaid CMI and the total number of Medicaid discharges for the aggregate group in order to derive the additional amount of reimbursement Medicare would have paid for the Medicaid services. Payments are trended forward to account for differences from the base year to the current period.

1. Determination of Medicare Reimbursements per Discharge

CMS' Medicare rules provide for several distinct reimbursement components under the Acute Inpatient Prospective Payment System. Texas' Medicaid UPL calculation methodology recognizes that some Medicare reimbursement components are subject to case mix adjustments to reflect acuity, and other components are based on cost, number of residents, volume of Medicare patients, or other factors unrelated to acuity. Consequently, Texas divides Medicare payments subject to case mix adjustment by the CMI, and treats the remaining Medicare reimbursement components as pass-through payments. The attached workbook titled "Aggregate Inpatient UPL Demonstration - 2006" sets forth the methodology used to demonstrate the three different aggregate Medicaid UPLs and lists the corresponding items from the Medicare cost report as the source data for each type of Medicare payment for hospital inpatient services.

The base year Medicare and Medicaid data used to calculate the aggregate Medicaid UPL is State Fiscal Year/cost reporting year 2003. Medicare data was extracted from the CMS Healthcare Provider Cost Reporting Information System ("HCRIS") file for the first quarter of 2005, the most recent file available at the time Texas submitted the State Plan Amendment to CMS. At that time, not all hospitals had filed a cost report for their 2004 cost reporting year. Rather than mixing the

2003 and 2004 data, Texas elected to use the same year data for all hospitals, and 2003 data was the most recent year for which the HCRIS file contains a full year of data.

The Medicare Acute Inpatient Prospective Payment System inflates the standardized amount components each year based on the wage index and cost of living adjustment factors. In order to trend the Medicare data forward, Texas applied CMS' inflation updates for the 2004, 2005, and 2006 periods.

2. Determination of Medicaid Reimbursements per Discharge

Texas used 2003 as the base year period for determining Medicaid payments per discharge in the inpatient aggregate Medicaid UPL demonstrations. Texas selected 2003 data as the base year to be consistent with the Medicare data described above. Since 2003, Texas has made several adjustments to Medicaid reimbursements that result in adjustments to the base year payments in the demonstrations. Texas obtained Medicaid reimbursement data from its systems for State Fiscal Year 2003. In order to trend the 2003 data forward to 2006, Texas revised the 2003 data for systemic changes in the Texas Medicaid program.

In 2003, hospitals received enhancements to their Medicaid standard dollar amount ("SDA") of 10.25 percent for high-volume Medicaid providers in large urban areas and 6.5 percent for high-volume providers in other urban areas. Texas also implemented a 2.5 percent decrease in traditional Medicaid hospital inpatient reimbursement rates on September 1, 2003, for State Fiscal Year ("SFY") 2004 and an additional 2.5 percent Medicaid reimbursement rate decrease for SFY 2005. In addition to these rate cuts, Texas eliminated the inflationary adjustment factor in SFY 2004 and has not re-based traditional Medicaid reimbursement rates since 2000. Texas has continued to freeze reimbursement rates at the SFY 2005 levels for SFY 2006. In addition to these rate reductions, hospitals' SDA were reduced in SFYs 2004 and 2005 to remove a high-volume provider enhancement. The removal of the high-volume enhancement reduced traditional inpatient hospital reimbursements by 10.25 percent for high-volume Medicaid providers in large urban areas and 6.5 percent for high-volume Medicaid providers in other urban areas from 2003 to 2005, on top of the 5 percent rate reductions.

Similar to Medicare reimbursements, Texas's Medicaid program includes payments that are adjusted for patient acuity and pass-through payments based on costs. Consequently, Texas adjusted the revised inpatient payments subject to patient acuity by dividing the payments by the Medicaid CMI and then added Medicaid outliers as pass-through payments. Texas has ceased funding Medicaid GME.

Consequently, Texas removed the GME payments from Medicaid reimbursements when calculating the aggregate Medicaid UPL demonstration.

3. Summary of Inpatient Aggregate Medicaid UPL Demonstrations

Exhibit E, the attached worksheet, "Aggregate Inpatient UPL Demonstration – 2006," contains the demonstrations for the three classes of hospitals (State-owned or operated, other government-owned or operated, and private), and compares the aggregate inpatient Medicaid UPL to the estimated Medicaid UPL payments to be made to each group of hospitals in SFY 2006. The results are as follows:

Class of Hospitals	Inpatient Aggregate Medicaid UPL	Estimated UPL Funding SFY 2006
State Hospitals	$ 86,214,017	$ 65,264,559
Public Hospitals	$ 744,273,506	$ 693,788,327
Private Hospitals	$ 1,090,918,266	$ 225,876,422

This methodology demonstrates that the estimated inpatient Medicaid UPL payments for State, public, and private hospitals do not exceed the aggregate inpatient Medicaid UPL for any class of hospitals.

14. Does any public provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

In the aggregate, payments to public hospitals do not exceed the uncompensated care cost of providing services.

Funding Questions – Attachment 4.19-B

Although some description of funding sources was included in part of the initial submission, the information appears to blend both Attachment 4.19-A and Attachment 4.19-B. In addition, the information provided was not comprehensive. For Attachment 4.19-B, please provide responses for all outpatient hospital payments.

15. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary

organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Medicaid payments (including fee schedule, interim, supplemental or enhanced payments) are made directly to Medicaid providers. Neither the State, local government, nor any other intermediary organization retains any portion of the Medicaid payment.

In order to ensure that providers will not return any portion of the supplemental Medicaid payments they receive to the local government funding source, we are requiring each hospital to independently certify that it will not return any of the supplemental payments it receives to the local government entity that provides the non-Federal share. We are also requiring the local government entities to execute similar forms certifying that they will not receive any portion of the supplemental Medicaid payments made to the hospitals under these programs. A copy of the certification forms we plan to use are enclosed with these responses for your review (Exhibits C and D).

16. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the State share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the State share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the State to provide State share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-Federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the State agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(vi) a complete list of the names of entities transferring or certifying funds;
(vii) the operational nature of the entity (State, county, city, other);
(viii) the total amounts transferred or certified by each entity;
(ix) clarify whether the certifying or transferring entity has general taxing authority; and,

(x) whether the certifying or transferring entity received appropriations (identify level of appropriations).

The State share of funds used to draw down Federal funds for the Texas Medicaid FFS outpatient payments (TEFRA cost based payments) and Medicaid Managed Care payments use general revenue.

The State share of funds used to draw down Federal funds for Texas Medicaid Supplemental outpatient payments comes from intergovernmental transfers from public hospitals, hospital districts, or other public entities. The intergovernmental transfers are used to provide the State share of matching funds. The State and Federal funds are then used to reimburse non-State hospitals participating in the currently approved supplemental payment plans.

No CPEs are used to provide the State share of any type of outpatient hospital Medicaid payment made pursuant to Attachment 4.19-B. All entities other than the State that provide the State's share of a Medicaid payment do so using IGTs. All entities that provide IGTs have general taxing authority and do not receive any appropriations to fund the Medicaid program.

The State's share of Medicaid supplemental payments made pursuant to Attachment 4.19-B, paragraphs 8 and 9, are provided using IGTs from local government entities. This process is effected through an ACH Authorization Agreement for Automatic Withdrawals ("ACH Agreement") between the local governmental entity and the Texas Comptroller's Office ("Comptroller"). Under the terms of the ACH Agreement, the local governments authorize the Comptroller to electronically withdraw funds from the local governmental account on a quarterly basis in order to fund the non-Federal share of Medicaid supplemental payment programs.

HHSC calculates the amount of each local government's IGT based on available Medicaid UPL cap room for the hospitals receiving supplemental Medicaid reimbursement, after subtracting the amount of all inpatient Medicaid payments. HHSC then provides each local governmental entity's IGT amount to the Comptroller (inpatient and outpatient combined), and also provides notice, typically seven to ten days in advance, to the local governmental entity. Historically, the Comptroller has electronically withdrawn the local governmental funds pursuant to the ACH Agreement on a Monday, and supplemental Medicaid reimbursement payments (inpatient and outpatient combined) are disbursed to eligible providers four days later. The amount of the local governmental IGTs under SPA TX-05-011 will be limited by the amount of available Medicaid UPL cap room.

Class of Hospitals	Outpatient FFS	Outpatient Managed Care	Outpatient Supplemental
Total Payment	$ 508,355,887	$ 221,543,656	$ 9,679,537
Non-Federal Share	$ 198,919,658	$ 86,690,032	$ 3,787,603

17. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. For each type of supplemental or enhanced payments made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Attachment 4.19B Supplemental Payments

	Urban	Rural	State-Owned
SFY 2004 Supplemental	**$9,679,537**	**$0**	**$0**
State Share	**$3,787,603**	**$0**	**$0**
SFY 2005 Supplemental	**$10,041,719**	**$0**	**$0**
State Share	**$3,929,325**	**$0**	**$0**

18. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-State government owned or operated, and privately owned or operated).

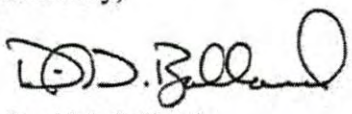
As a group, the hospitals within each class of providers described above are prohibited from receiving more than "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles" in outpatient Medicaid payments. Under Medicare payment principles, hospitals are paid based on cost for outpatient hospital services. In Texas, hospitals are paid less than cost for outpatient hospital Medicaid claims, as discussed in greater detail in the State's responses to Questions 7 and 8. As a result of cost reductions applied by the State, the amount of outpatient hospital unreimbursed cost eligible for Medicaid supplemental reimbursement is less than the amount of outpatient cost eligible for Medicare reimbursement. Because each individual hospital is never paid more than Medicaid eligible cost in a Medicaid outpatient hospital payment, and Medicaid eligible outpatient cost is less than Medicare eligible outpatient cost, the State confirms that it will not make payments that exceed the UPL at 42 CFR § 447.321.

19. Does any public provider receive payments that in the aggregate (normal per diem, DRG, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

    In the aggregate, payments to public hospitals do not exceed the uncompensated care cost of providing services.

Please let me know if you have any questions or need additional information. Arnulfo Gomez, Program Development Support, serves as the lead staff on this matter and can be reached at (512) 491-1166 or by e-mail at arnulfo.gomez@hhsc.state.tx.us.

Sincerely,



David J. Balland
State Medicaid Director

Attachments

DB: ag

cc: J. P. Peters, CMS

bcc: Kevin Niemeyer, HHSC
Alisa Jacquet, HHSC
Arnulfo Gomez, HHSC

EXHIBIT 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

Mr. Chris Traylor
State Medicaid Director
Texas Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711

SEP - 5 2006

RE: TN 05-011

Dear Mr. Traylor:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 05-011. This revises the payment methodology for inpatient and outpatient hospital services. Effective November 12, 2005 qualifying private hospitals will receive supplemental payments.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A and Attachment 4.19-B. Based upon the assurances provided, we are approving Medicaid State plan amendment 05-011, effective November 12, 2005. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Billy Bob Farrell at (214) 767-6407 or Sandra Dasheiff at 214-767-6490.

Sincerely,

Dennis G. Smith
Director

Enclosures

RECEIVED
SEP 14 2006
HHSC - MEDICAID/CHIP

original received

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **TX 05-011**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **November 12, 2005**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.272

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2006** **$258,662,000**
b. FFY **2007** **$304,977,000**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT

10. SUBJECT OF AMENDMENT:
Establishes supplemental upper payment limit (UPL) payments for services provided by non-publicly owned hospitals.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
David J. Balland

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:

16. RETURN TO:
Chris Traylor
~~David J. Balland~~
State Medicaid Director
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
September 5, 2006

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Dennis G. Smith

22. TITLE:
Director, CMSO

23. REMARKS:

FORM HCFA – 179 (07-92)

(8) Notwithstanding other provisions of this attachment, supplemental payments will be made each state fiscal year in accordance with this subsection to eligible hospitals that serve a high volume of Medicaid and uninsured patients.

(a) Supplemental payments are available under this subsection for outpatient services provided by a publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis counties on or after July 6, 2001. Supplemental payments will be made for outpatient services on or after June 11, 2005 for Midland, Potter, and Randall Counties.

(b) The supplemental payments described in this subsection will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 C.F.R. § 447.321.

(1) In each county listed in paragraph (8)(a) of this section, the publicly-owned hospital or hospital affiliated with the hospital district that incurs the greatest amount of cost for providing services to Medicaid and uninsured patients, will be eligible to receive supplemental high volume outpatient payments.

(2) The supplemental payments authorized under this subsection are subject to the following limits:

(i) Except for hospitals eligible under (8)(c), in each state fiscal year the amount of any inpatient supplemental payments and outpatient supplement payments may not exceed the hospital's "hospital specific limit," as determined under Appendix I to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals [DSH]) for DSH hospitals; and

(ii) The amount of outpatient supplemental payments and fee-for-service Medicaid outpatient payments the hospital receives in a state fiscal year may not exceed Medicaid billed charges for outpatient services provided by the hospital to fee-for-service Medicaid recipients.

(c) Notwithstanding the provisions of subsections (8)(a) and (8)(b)(1) above, all hospitals that are eligible to receive funding under section (t)(4) of Attachment 4.19-A shall also be eligible to receive funding under section (8). Supplemental payments will be made for outpatient services on or after June 11, 2005 for eligible hospitals in Hidalgo, Maverick, Montgomery, Travis, Bexar, and Webb Counties. Supplemental payments will be made for outpatient services on or after November 12, 2005 for all other eligible hospitals under the terms of this subsection.

(d) An eligible hospital will receive quarterly supplemental payments. The quarterly payments will be one-fourth of the difference between the hospital's Medicaid fee-for-service outpatient Medicaid payments received and 100% of Medicaid allowable outpatient hospital cost as derived by applying the ratio of cost to charges from Worksheet D, Part V of the cost report to Medicaid outpatient charges associated with paid claims as reported by HHSC. Medicaid payments and cost will be based on a twelve consecutive-month period of fee-for-service claims data selected by HHSC.

STATE Texas DATE RECD 12-28-05 DATE APPVD SEP - 5 2006 DATE EFF 11-12-05 HCFA 179 TN 05-011	A

SUPERSEDES TN 05-001

(5) An eligible hospital under section (t)(4) will receive quarterly supplemental payments. The quarterly payments will be one-fourth of the lesser of:

(A) The difference between the hospital's Medicaid inpatient billed charges and Medicaid payments the hospital receives for services provided to fee-for-service Medicaid recipients. Medicaid billed charges and payments will be based on a twelve consecutive-month period for fee-for-service claims data selected by HHSC; or

(B) The difference between the hospital's "hospital specific limit", as determined under Appendix I to Attachment 4.19A (relating to Reimbursement to Disproportionate Share Hospitals (DSH)) for DSH hospitals and the hospital's DSH payments as determined by the most recently finalized DSH reporting period.

(6) For purposes of calculating the "hospital specific limit" under this subsection, the "cost of services to uninsured patients" and "Medicaid shortfall," as defined by Appendix I to Attachment 4.19-A, the amount of Medicaid payments (including inpatient and outpatient supplemental payments) that exceed Medicaid cost will be subtracted from the "cost of services to uninsured patients" to ensure that during any state fiscal year, a hospital does not receive more in total Medicaid payments (inpatient and outpatient rate payments, graduate medical education payments, supplemental payments and disproportionate share hospital payments) than their cost of serving Medicaid patients and patients without health insurance.

(u) High Volume Medicaid Payments. High-volume payments recognize the higher medical assistance costs and indigent care cost of hospitals that treat higher levels of low-income and indigent patients. Eligible hospitals are defined as non-state owned or operated, non-public hospitals located in urban counties. An urban county is classified by the federal Office of Management and Budget and defined as a county that has a city or urbanized area with a population greater than 50,000 according to 2000 United States census data. High-volume payments not exceeding $26,400,000 shall be allocated in proportion to uncompensated care loss for eligible hospitals participating in the current year DSH program. Payments under this provision will be made annually based on current year finalized Medicaid DSH claims data. The state shall adjust the high volume payments in accordance with applicable Medicaid charge upper limit regulations. Any adjustment shall be made on a proportional basis in order to allow eligible hospitals to participate to the fullest extent possible within the limits on disproportionate share hospital payments. HHSC shall use current year DSH data to determine Medicaid days. County population will be based on the 2000 United States census.

SUPERSEDES: TN TN 05-012

STATE Texas	A
DATE RECD 12-28-05	
DATE APPVD SEP - 6 2006	
DATE EFF 11-12-05	
HCFA 179 TN 05-011	

(t) Non-State Owned Hospital Supplemental Inpatient Payments. Notwithstanding other provisions of this attachment, supplemental payments will be made each state fiscal year in accordance with this subsection to eligible hospitals that serve high volumes of Medicaid and uninsured patients.

(1) Supplemental payments are available under this subsection for inpatient hospital services provided by a non-state owned or operated publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Midland, Potter, Randall, Tarrant, and Travis Counties. Supplemental payments will be made for inpatient services on or after July 6, 2001 for Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis Counties. Supplemental payments will be made for inpatient services on or after February 7, 2004 for Midland County. Supplemental payments will be made for inpatient services on or after May 29, 2004 for Potter and Randall Counties.

(2) The supplemental payments described in this subsection will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 C.F.R. § 447.272. The following method is used to reasonably estimate the Medicaid upper limit. Medicare payments subject to case mix adjustment are divided by a hospital's Medicare case mix index (CMI) to determine total Medicare payments for case mix of 1.0. Medicare pass-through payments are added, and the total is divided by Medicare discharges in order to determine a Medicare CMI adjusted payment per discharge. Medicaid payments subject to case mix adjustment are divided by a hospital's Medicaid CMI to determine total Medicaid payments for a case mix of 1.0. Medicaid pass-through payments are added, and the total is divided by Medicaid discharges in order to determine a Medicaid CMI adjusted payment per discharge. The Medicaid CMI adjusted payment per discharge is subtracted from Medicare CMI adjusted payment per discharge. The result is multiplied by the hospital's base year Medicaid CMI to determine a CMI adjusted Medicaid Medicare payment per discharge differential. This payment per discharge differential is multiplied by Medicaid base year discharges and inflated to the current period. The calculation uses base year paid Medicaid claims and cost reports. All managed care patients are excluded from the calculation.

(3) In each county listed in paragraph (t)(1) of this section, the publicly-owned hospital or hospital affiliated with a hospital district that incurs the greatest amount of cost for providing services to Medicaid and uninsured patients, will be eligible to receive supplemental high volume payments. The supplemental payments authorized under this subsection are subject to the following limits:

(A) In each state fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments may not exceed the hospital's "hospital specific limit," as determined under Appendix I to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals (DSH)) for DSH hospitals; and

(B) The amount of inpatient supplemental payments and fee-for-service Medicaid inpatient payments the hospital receives in a state fiscal year may not exceed Medicaid inpatient billed charges for inpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 C.F.R. § 447.271.

(4) Notwithstanding the provisions of subsections (t)(1) and (t)(3) above, -hospitals with an indigent care affiliation agreement with a hospital district or other local government entity shall be considered eligible to receive supplemental payments under this section (t). Supplemental payments will be made for inpatient services on or after June 11, 2005 for eligible hospitals in Hidalgo, Maverick, Montgomery, Travis, Bexar, and Webb Counties. Supplemental payments will be made for inpatient services on or after November 12, 2005 for all other eligible hospitals.

STATE Texas DATE RECD 12-28-05 DATE APPVD SEP - 5 2006 DATE EFF 11-12-05 HCFA 179 TN 05-011	A

SUPERSEDES: TN 05-001

EXHIBIT 4

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

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[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.

[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%

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[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 5

Payments cannot exceed the actual cost of providing services to Medicaid beneficiaries and the uninsured as defined in the cost claiming protocol.

ii. **UC Application.** To qualify for a UC Payment, a provider must submit to the state an annual UC Application that will collect cost and payment data on services eligible for reimbursement under the UC Pool. Data collected from the application will form the basis for UC Payments made to individual hospitals and non-hospital providers. The state must require hospitals to report data in a manner that is consistent with the Medicare 2552-96 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles.

(A) After CMS has approved the applicable protocol, the state may begin accepting applications from providers for UC Payments in DY 1. Thereafter, providers are required to submit their UC Applications to the State by September 30 of each year, in order to qualify for a UC Pool payment for the DY that begins on October 1st.

(B) Cost and payment data included on the application must be based on the Medicare 2552-96 cost report, or for non-hospital providers, a CMS-approved cost report consistent with Medicare cost reporting principles for a federal fiscal year (FFY) that is two years prior to the DY in which UC Payments are to be made, in order to allow time for providers to finalize their cost reports from that data year and submit their application data to HHSC. (For example, FFY 2010 would be the data year for UC Payments under the UC pool in DY 1.) The state may trend the data to model costs incurred in the year in which payments are to be made. Subsequent DY applications will be used to reconcile estimates for prior years. For example, uncompensated care cost data from a DY 3 application will be used to determine the actual uncompensated care for DY 1 UC Payments for a qualifying provider. Any overpayments identified in the reconciliation process that occurred in a prior year must be recouped from the provider, with the FFP returned to CMS. During the reconciliation process, if a provider demonstrates that it has allowable uncompensated costs consistent with the protocol that were not reimbursed through the initial UC Payment (based on application figures), and the state has available UC Pool funding for the year in which the costs were accrued, the state may provide reimbursement for those actual documented unreimbursed UC costs through a prior period of adjustment.

(C) Any provider that meets the criteria below may submit a UC Application to be eligible to receive a UC Payment.

(I) Private providers must have an executed indigent care affiliation agreement on file with HHSC.

EXHIBIT 6

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

JAN 07 2015

Kay Ghahremani
Director
Texas Health and Human Services commission
P.O. Box 13247
Austin, Texas 78711

Dear Ms. Ghahremani:

Thank you for the information you and your staff have provided related to a recent deferral the Centers for Medicare & Medicaid Services (CMS) issued regarding the non-federal share financing of Texas' Uncompensated Care under its section 1115 waiver. As we discussed, CMS is releasing the deferral that was issued in September 2014 for expenditures claimed on the Quarterly Medicaid Statement of Expenditures (Form CMS-64) for the quarter ended June 30, 2014 while we complete our work together on this issue.

Please note that release of the deferral does not constitute CMS' acceptance of the financing arrangements. CMS is committed to performing a thorough analysis of all of the materials provided by the state before making any final determinations and to provide Texas with necessary technical assistance to correct any deficiencies. As you know, CMS issued clarifying guidance related to provider-related donations on May 9, 2014; as such, we believe it is best to work with Texas to ensure understanding of all of the financing arrangements within Texas and make appropriate determinations and any necessary adjustments going forward. In order to review and analyze all relevant information and to the extent that CMS determines that any financing structure within Texas' Medicaid program violates federal statute and regulation, we would expect Texas to make necessary adjustments by December 2015.

Thank you again and let me know if you have any questions.

Sincerely,

Timothy Hill
Deputy Director

cc: Bill Brooks, Associate Regional Administrator,
Division of Medicaid and Children's Health Operations,
Region VI

Dorothy Ferguson, Financial Management Branch Chief,
Division of Medicaid and Children's Health Operations,
Region VI

EXHIBIT 7

From:	Hill, Timothy B. (CMS/CMCS)
To:	Leo,Monica (HHSC)
Cc:	Fan, Kristin A. (CMS/CMCS); Greenberg,Charles (HHSC); Kirsch,Lisa (HHSC); McDonald,Pam (HHSC); Young,Gary (HHSC); Khalsa,Ardas (HHSC)
Subject:	RE: Private Hospital funding -- confirmation of transition schedule
Date:	Tuesday, June 09, 2015 8:44:41 AM

Sorry for the delay. Your understanding of the timeline is correct.

From: Leo,Monica (HHSC) [mailto:Monica.Leo@hhsc.state.tx.us]
Sent: Friday, May 29, 2015 5:13 PM
To: Hill, Timothy B. (CMS/CMCS)
Cc: Fan, Kristin A. (CMS/CMCS); Greenberg,Charles (HHSC); Kirsch,Lisa (HHSC); McDonald,Pam (HHSC); Young,Gary (HHSC); Khalsa,Ardas (HHSC)
Subject: Private Hospital funding -- confirmation of transition schedule

Hi Tim,

I understand from Kristin Fan that you were able to confirm with CMS' leadership that Texas will have until September 2017 to make any changes to private hospital funding that may be required following our scheduled discussions this summer. By that, we understand CMS to authorize the current private-hospital funding arrangements to continue for waiver-payment dates through August, 2017, without risk of disallowance of federal matching funds on the same grounds questioned in last year's deferral. Waiver payments made to private hospitals after that date would be at risk if agreed-to changes are not made. We plan to start taking steps right away to implement any required changes, but this schedule recognizes the lengthy process that may be required at both local and state levels.

I would appreciate your confirmation by reply email of our understanding of this agreement.

Our discussions with Kristin and other members of your staff so far have been informative and helpful to HHSC in understanding CMS' position on these funding relationships. We appreciate CMS' commitment to working through our differences.

Thank you,

MONICA LEO
SPECIAL COUNSEL FOR SYSTEM SUPPORT
HEALTH & HUMAN SERVICES COMMISSION
(512) 424-6558

EXHIBIT 8

From: Fan, Kristin A. (CMS/CMCS)
To: Sampson, Tamara L. (CMS/CMCHO); Branch, Jeoffrey A. (CMS/CMCHO); Pahl, Mark W. (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); MacCarroll, Amber L. (CMS/CMCS); Howe, Rory (CMS/CMCS); Goldstein, Stuart S. (CMS/CMCS); Leo,Monica (HHSC); Hill, Timothy B. (CMS/CMCS)
Cc: Brooks, Bill D. (CMS/CMCHO); Ferguson, Dorothy A. (CMS/CMCHO); Farrell, Billy B. (CMS/CMCHO); Freeze, Janet G. (CMS/CMCS); Harrison, Wendy L. (CMS/CMCS); Lane, Robert (CMS/CMCS); Silanskis, Jeremy D. (CMS/CMCS)
Subject: RE: Private Hospital funding -- topics for discussion
Date: Tuesday, September 15, 2015 8:24:00 AM

Monica,

I hope you had a wonderful vacation. I think we can cancel for today. We have received all of the information and I don't think we have any other questions that need to be answered. We are working with our leadership to discuss next steps. I think Tim discussed some of this when he was visiting in late August. If you'd like to discuss further, I can give you a call.

Kristin

-----Original Appointment-----
From: Sampson, Tamara L. (CMS/CMCHO)
Sent: Tuesday, May 12, 2015 2:06 PM
To: Sampson, Tamara L. (CMS/CMCHO); Branch, Jeoffrey A. (CMS/CMCHO); Pahl, Mark W. (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); MacCarroll, Amber L. (CMS/CMCS); Howe, Rory (CMS/CMCS); Goldstein, Stuart S. (CMS/CMCS); Fan, Kristin A. (CMS/CMCS); Leo,Monica (HHSC) (Monica.Leo@hhsc.state.tx.us); Hill, Timothy B. (CMS/CMCS)
Cc: Brooks, Bill D. (CMS/CMCHO); Ferguson, Dorothy A. (CMS/CMCHO); Farrell, Billy B. (CMS/CMCHO); Freeze, Janet G. (CMS/CMCS); Harrison, Wendy L. (CMS/CMCS); Lane, Robert (CMS/CMCS); Silanskis, Jeremy D. (CMS/CMCS)
Subject: Private Hospital funding -- topics for discussion
When: Tuesday, September 15, 2015 2:00 PM-3:00 PM (UTC-06:00) Central Time (US & Canada).
Where: CMS Dallas Room 832

Good Afternoon,

We will start the Texas private hospital funding discussions on Tuesday afternoons. The first discussion will be held on May 19 at 2:00 CST.

Following is the proposed Texas Agenda:

May 19 - Session 1: Overview

- Types of Governmental Entities that IGT for private hospitals (significance to application of state law indigent obligations)
- Indigent Care Affiliation Agreements -- history and use in UPL; discussion of continued viability in current form

May 26- Session 2: Chapter 61, Texas Health and Safety Code, and other relevant state law

- Counties
- Hospital Districts
- Other governmental entities

June 2- Session 3: Community Benefit Model

- Parkland (physician contract or other non-indigent-care benefit)
- Nueces County hospitals other than Christus (indigent care benefit)

June 9 - Session 4: Christus/Nueces Model

June 16 - Session 5: Seton/Central Health/CCC Model

June 23- Session 6: Conclusion

- Confirm areas of agreement
  - Aspects of current models that CMS agrees do not require change
  - Aspects of current models that HHSC agrees to change (conditioned on legislative action, if required)
- Identify remaining areas of disagreement, if any, and develop strategy for resolving those differences

The goal is to have a plan in place by the end of summer and before the deadline for the submission of the waiver renewal request. This should give Texas time to transition to other funding models, should changes be required following our discussions over the coming months.

If there are any problems with conference call information, then please contact me at 214-767-6431.

Thanks,

Tamara Sampson
Health Insurance Specialist for the National Institutional Reimbursement Team
Centers for Medicare & Medicaid Services¦Dallas Regional Office¦ Region VI¦ Division of Medicaid and Children's Health¦ 1301 Young St., Room 827, Dallas, TX 75202 ¦ Tamara.Sampson@cms.hhs.gov ¦(214) 767- 6431¦(214) 767- 0322 Please consider *the environment before printing this e-mail.*

Tamara Sampson invites you to an online meeting using WebEx.

Meeting Number: 996 989 440
Meeting Password: This meeting does not require a password.

Audio conference information

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1. Please call the following number:
WebEx: 1-877-267-1577
2. Follow the instructions you hear on the phone.
Your WebEx Meeting Number: 996 989 440

To join from a Cisco VoIP enabled CMS Region or from CMS Central Office

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1. Dial ext. 63100
2. Enter the Meeting Number: 996 989 440

To join this meeting online

---

1. Go to https://cms.webex.com/cms/j.php?J=996989440
2. If requested, enter your name and email address.
3. If a password is required, enter the meeting password: This meeting does not require a password.
4. Click "Join".
5. Follow the instructions that appear on your screen.

EXHIBIT 9

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

May 1, 2008

Mr. James Frizzera, Director
Financial Management Group S3-13-23
Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Deferrals ##TX/2007/3/E/11/MAP; TX/2007/3/E/12/MAP; TX/2007/4/E/15/MAP

Dear Mr. Frizzera:

The purpose of this letter is to set forth the steps that the Texas Health and Human Services Commission (the Commission or HHSC) proposes be taken to resolve the outstanding issues that have arisen in the private hospital UPL program as reflected in the deferral letters that CMS has issued:

- Letter of October 5, 2007, deferring $37,583,374 in FFP (deferral #1);
- Letter of October 5, 2007, deferring $72,633,689 in FFP (deferral #2); and
- Letter of January 28, 2008, deferring $50,052,809 in FFP (deferral #3).

After careful consideration and review, the Commission has determined that it should not pursue certain of the claims covered by deferral #1, but that the claims covered by deferrals ## 2 and 3 are consistent with federal law and the state plan. At the same time the Commission has developed a set of criteria to guide hospitals participating in the private hospital UPL program in the future. A copy of the criteria is attached.

The expenditures reported in the CMS-64 form for the quarter ending June 30, 2007, that are the subject of deferral #1 totaled $157,662,161.21. Of this amount, $61,835,099.63 was derived from intergovernmental transfers (IGTs) that CMS has questioned based on a concern that the transferred funds were recouped by the transferring local government entities from the private hospitals receiving the UPL payments. In light of that concern, we will reduce our claimed expenditures by the amount of the IGTs so questioned. This will reduce the State's FFP claim by the amount of the deferral ($37,583,374).

We have made this adjustment on the appropriate CMS form for the quarter ending March 31, 2008, which we submitted on April 30, 2008. In order to clarify this disposition for accounting

and reconciliation purposes, we request that CMS take the necessary steps to withdraw deferral #1.

In our letters to CMS dated February 4, 2008, relating to deferral #2, and March 31, 2008, relating to deferral #3, we have set forth the basis for our determination, after investigation and review, that the claims covered by those deferrals were proper and qualified for FFP. We ask that CMS also take the necessary steps to withdraw these deferrals, so that the State may immediately receive the FFP withheld by deferral letters ##2 and 3.

The Commission does not intend to recover from the private hospitals any of the payments made to them that are the subject of deferral #1. However, it does intend to retain, from future IGTs from local government entities that are in excess of the amounts needed to fund the non-federal share of UPL payments, amounts equal to the amount covered by deferral #1. In this manner, the excess IGTs will replace the federal funds, covered by deferral #1, that the State did not receive.

Use of the payments made by HHSC to the private hospitals in the UPL program during the period in which HHSC retains excess portions of the IGTs (as well as thereafter) will be governed by the criteria referred to previously and attached to this letter, as well as by applicable federal and state laws and regulations.

We would appreciate your confirmation that the resolution of the issues outlined in this letter are satisfactory to CMS, and that it will release the funds covered by deferrals ##2 and 3 in accordance with the foregoing.

Sincerely,

Chris Traylor
Associate Commissioner for Medicaid and CHIP

Attachment

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

Attachment

Prospective Conditions of Participation
in the
Texas Private Hospital Upper Payment Limit
Supplemental Reimbursement Program

Prospective Conditions of Participation in the Texas Private Hospital Upper Payment Limit Supplemental Reimbursement Program

In consideration of the resolution of the pending deferrals of the State of Texas' requests for federal financial participation pursuant to the Texas Private Hospital Upper Payment Limit (UPL) supplemental payment program, the Texas Health and Human Services Commission will establish additional conditions of participation by private hospitals and local governmental entities. The conditions will be effective upon resumption of the supplemental payments and will apply to all payments made after April 15, 2008.

I. No linkage between Indigent Care obligations and UPL Payments

The indigent care obligation of a private hospital that is affiliated with a governmental entity for purposes of participation in the Private Hospital UPL supplemental payment program will not be conditioned or measured by the amount of supplemental payments a private hospital receives under the program. Likewise, the amount of supplemental payments a private hospital receives under the Private Hospital UPL supplemental payment program will not be conditioned or measured by the amount of indigent care the private hospital provides, subject to the documentation and evaluation conditions described in sections I.A and III below. A participant may consider the amount of supplemental payments it expects to receive in deciding whether, and to what degree, it will participate in the indigent care program. A government entity may consider the historical experience in the indigent care program in deciding whether to make an intergovernmental transfer of funds, or the amount of such a transfer.

A private hospital receiving UPL supplemental payments may not be assigned the indigent care contractual or statutory obligations of a transferring governmental entity. However, a private hospital that receives UPL supplemental payments may provide indigent care by entering into its own arrangements (contractual or otherwise) with health care providers that had previously provided indigent care services to the transferring governmental entity.

A. Permissible documentation

In determining whether to make an intergovernmental transfer of funds to provide the state share of supplemental payments and/or the amount of such a transfer, a governmental entity may rely on documentation that demonstrates the amount and types of indigent care needs in the community and the amount and types of health care (including indigent health care and Medicaid services) historically provided in the community. The governmental entity may not condition the amount to which it funds the non-Federal share of supplemental payments on a specified or required minimum amount of prospective indigent care.

Any documentation utilized in connection with intergovernmental transfers of funds shall be publicly available for review.

B. Certification

HHSC will require certifications from both funding governmental entities and private hospitals that affirm the following:

(1) That there is no agreement to condition the amount transferred by the government entities nor the amount of UPL payments on the amount of indigent care a private hospital has provided or will provide;

(2) That there is no agreement to condition the amount of the private hospital's indigent care obligation on the amount transferred by the government entities nor the amount of any UPL payment the hospital might receive;

(3) That no escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of indigent care services provided or to be provided by private hospitals receiving UPL supplemental payments; and that any escrow, trust or other funding mechanism utilized in connection with an anticipated intergovernmental transfer from a governmental entity has been disclosed to HHSC and is in no way intended to facilitate or constitute a quid pro quo for the provision of indigent care services by or on behalf of the private hospitals; and

(4) That the governmental entity has not received and will not receive refunds of payments the governmental entity made or makes to the private hospitals for any purpose in consideration for an IGT by the government entity to fund UPL supplemental payments.

A governmental entity may retrospectively evaluate the amount and impact of a hospital's indigent care delivery during the period it receives supplemental payments and can rely on such historical information in determining whether, and to what degree, it will provide an IGT and/or set aside government funds in an escrow account in the future.

II. No cash or in-kind transfers

The Private Hospital UPL program must not include cash or in-kind transfers from affiliated private hospitals to the governmental entities that supply the IGT to fund the state share of UPL payments other than transfers and transactions that are unrelated to the administration of the Private UPL program and/or the delivery of indigent care services and represent:

(1) Fair market value for goods and/or services rendered to the private hospital; and

(2) Independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the hospital and the governmental entity.

III. Performance evaluations allowable

A. Authority of Governmental Entity to Evaluate Impact

A governmental entity that supplies the intergovernmental transfer to fund the state share of UPL payments must, consistent with its fiduciary duty under the Texas Constitution and state law, have the ability to determine whether its investment of taxpayer funds increases the level of indigent care provided in the community and improves access to care for the needy in its community.

B. Audit Authority

To that end, a governmental entity may implement reasonable pre- and post performance evaluation measures to—

(1) Determine whether to execute an affiliation agreement with a private hospital;

(2) Determine whether to continue an affiliation agreement with a private hospital; and

(3) Provide accountability to local taxpayers.

C. Pre-performance Evaluation Criteria

A governmental entity may consult with community leaders, advocates for the poor, and other stakeholders in assessing the opportunities to improve access to health care for indigent persons residing in the community through participation in the UPL program. These efforts can be documented in a form acceptable to the governmental entity to confirm achievement of the governmental entity's mission and provide an appropriate and constitutional basis on which to supply local taxpayer funds to the State for the purpose of supplying the state share of costs.

This documentation, however, must not include:

(1) A commitment that a private hospital perform or supply an amount of indigent care that is determined or measured on the basis of the amount of UPL funds it receives; or, a commitment that a government entity will transfer as the non-Federal share of UPL payments an amount that is determined or measured by the amount of indigent care a hospital performs or supplies.

(2) An agreement to refund any type of payments made by the governmental entity to the private hospital; or

(3) An assessment of a hospital's performance based solely on the amount of services the hospital provides to Medicaid recipients.[1]

D. Post-performance Evaluation Criteria

[1] A governmental entity may take into account all forms of indigent care, charity care, or care to the needy an affiliated private hospital provides, including care to Medicaid recipients; provided, however, the amount of Medicaid services is not the sole criterion.

A governmental entity may retrospectively evaluate the performance of a private hospital that is affiliated with the governmental entity to determine whether the hospital's participation benefited the community and whether its continued participation in the program is likely to continue benefiting the community. The governmental entity may collect, analyze, and report such data to the taxpayers on a post-hoc basis on an annual, semi-annual, or quarterly schedule. The governmental entity may not attempt to recoup funds from a private hospital that it determines has not adequately performed under the affiliation agreement.

EXHIBIT 10

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 5, 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 11

HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF HOSPITAL PARTICIPATION
Version 2012-1 (09/05/2012)

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version of the Certification of Hospital Participation
Revision	1.1	09/05/2012	Added cover page.
Revision	1.2	09/05/2012	Added Document History Log.
Revision	1.3	09/05/2012	Various formatting changes.
Revision	1.4	09/05/2012	Added version number (Version 2012-1) and date of issuance to cover page and page footer.
Revision	1.5	09/05/2012	Deleted "Texas" from "Health and Human Services Commission" to reflect agency's statutory name.
Revision	1.6	09/05/2012	Revised paragraph 2.c.iii. to replace "and" at the end of clause 2. following the semicolon with "or."

[1] "Baseline" indicates initial document issuances, "Revision" indicates changes to the Baseline version, and "Cancellation" indicates withdrawn versions.

[2] Numbering conventions: Revisions are numbered according to the version of the document and the sequential revision—e.g., "1.2" refers to the first version of the document and the second revision.

[3] Brief description of the changes to the document made in the revision.

HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM
CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: .

On behalf of , a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, , affirm and certify the following:

1. ***Authorization.***

    a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

    b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. ***Assurances and Representations.***

    a. *Validity of Claims.* All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.

b. *Use of Supplemental Payments.*

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. *Agreements with Governmental Entity.*

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital's indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;

d. *Assignment/Assumption of Governmental Entity Obligations.*

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

(1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

(2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. *Use of Financial Mechanisms.* With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.

3. ***Deferral or Disallowance of Federal Financial Participation.***

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital's rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. ***Public Access to Affiliation Agreement.*** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

_____ _____

Signature Date

_____

Name and Title (print or type)

EXHIBIT 12

HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION FOR HOSPITAL AFFILIATES

Version 2012-1 (09/05/2012)

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version of the Certification of Governmental Entity Participation
Revision	1.1	09/05/2012	Added cover page.
Revision	1.2	09/05/2012	Added Document History Log.
Revision	1.3	09/05/2012	Various formatting changes.
Revision	1.4	09/05/2012	Added version number (Version 2012-1) and date of issuance to cover page and page footer.
Revision	1.5	09/05/2012	Deleted "Texas" from "Health and Human Services Commission" to reflect agency's statutory name.
Revision	1.6	09/05/2012	Revised paragraph 4.g. to replace "and" at the end of subparagraph ii following the semicolon with "or."

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[3] Brief description of the changes to the document made in the revision.

HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION FOR HOSPITAL AFFILIATES

On behalf of _____, a _____ organized under the laws of the State of Texas (hereinafter referred to as "the Governmental Entity"), I, _____, affirm and certify the following:

1. ***Legal Authorization.***

   a. The Governmental Entity is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds ("Public Funds");

   b. The Governmental Entity is legally authorized to enter into and has entered into Affiliation Agreements with one or more private hospitals ("the Affiliated Hospitals") for, among other purposes, providing indigent care in the community served by the Governmental Entity.

2. ***Public Adoption and Access.***

   a. The governing body of the Governmental Entity adopted the conditions described in this certification by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;

   b. Copies of all Affiliation Agreements will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.

3. ***Funding of Intergovernmental Transfers and Supplemental Payments.***

   a. The Governmental Entity has or has agreed to transfer Public Funds to the Health and Human Services Commission ("HHSC") via intergovernmental transfer ("IGT") for use as the non-federal share of supplemental waiver payments (the "Supplemental Payments") to the Affiliated Hospitals in accordance with 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program");

   b. All transfers of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments to the Affiliated Hospitals under the Waiver Program comply with:

      i. The applicable regulations that govern provider-related donations codified at section 1903(w) of the Social Security Act (42 U.S.C. §1396b(w)), and Title 42, Code of Federal Regulations, Part 433, subpart B, sections 433.52 and 433.54;

      ii. HHSC administrative rules codified at 1 Tex. Admin Code §355.8201, Waiver Payments to Hospitals.

4. ***Assurances and Representations.***

   a. The Governmental Entity does not and will not at any time receive any part of the supplemental payments that are made by HHSC to the Affiliated Hospitals under the Waiver Program;

   b. The Governmental Entity has not entered into a contingent fee arrangement related to the Governmental Entity's participation in the Waiver Program;

   c. The Governmental Entity has not entered and will not enter into any agreement to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments an Affiliated Hospital receives on the amount of indigent care the Affiliated Hospital has provided or will provide;

   d. The Governmental Entity has not entered and will not enter into any agreement to condition the amount of any Affiliated Hospital's indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment an Affiliated Hospital may be eligible to receive;

   e. With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care Affiliation Agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

f. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to an Affiliated Hospital for any purpose in consideration for an IGT of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments;

g. The Governmental Entity has not received and will not receive any cash or in-kind transfers from an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals other than transfers and transactions that:

i. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an Affiliation Agreement;

ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to an Affiliated Hospital; or

iii. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the Affiliated Hospital and the Governmental Entity;

h. The Governmental Entity has not:

i. Following the date this Certification was executed, assigned or agreed to assign a contractual or statutory obligation of the Governmental Entity to an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals; or

ii. Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

5. ***Evaluation.***

a. Consistent with its constitutional, statutory, and fiduciary obligations, the Governmental Entity may evaluate a private hospital's historical experience in providing indigent care in the community or performance under an Affiliation Agreement including the impact and amount of indigent care provided by the hospital, for the following purposes:

   i. To determine whether the Governmental Entity will enter into an Affiliation Agreement with a private hospital;

   ii. To determine whether and to what degree the Governmental Entity will supply an IGT, provided such decision does not include consideration of matters prohibited under paragraph 4 of this Certification;

   iii. To determine whether an Affiliated Hospital's participation benefited the community and whether its continued participation in the indigent care program is likely to continue to benefit the community; or

   iv. To provide accountability to local taxpayers;

b. The Governmental Entity's evaluation under this paragraph 5 may:

   i. Be documented in a manner sufficient to confirm achievement of the Governmental Entity's mission and provide an appropriate and constitutional basis on which to transfer the Public Funds to HHSC; and

   ii. Not include consideration of matters prohibited under paragraph 4 of this Certification ;

On behalf of the Governmental Entity, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind the Governmental Entity and to certify to the above.

_____ _____

Signature Date Official Seal (If applicable)

_____

Name and Title