DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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November 15, 2021

Stephanie Stephens
State Medicaid Director
Texas Health and Human Services Commission
4900 Lamar Boulevard
MC: H100
P.O. Box 13247
Austin, Texas 78751

Dear Ms. Stephens:

We appreciate your continued partnership during regular meetings with the Centers for Medicare & Medicaid Services (CMS) staff over the last few months. Our respective teams have worked to address the issues before us, and, with this letter, we are describing the current status of CMS's work with Texas, these outstanding issues, and next steps.

Background and Current Status

As you know, the Delivery System Reform Incentive Payment (DSRIP) program, which was authorized under the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) section 1115 demonstration, expired after September 30, 2021. In the final year of DSRIP, from October 1, 2020 until September 30, 2021, Texas was permitted to distribute up to $2.49 billion in incentive payments to hospitals and other providers. During that same period, Texas had approval of two state directed payments, consistent with federal regulations at 42 CFR 438.6, to direct managed care organizations to make additional payments to hospitals (in excess of the negotiated capitated rate) totaling approximately $3.7 billion. The combination of DSRIP payments and managed care state directed payments provided approximately $6 billion in Medicaid payments to hospitals above the payments those hospitals received for the delivery of services to Medicaid beneficiaries. In March 2021, Texas submitted applications (known as "preprints") for five state directed payment arrangements totaling approximately $7 billion for the state fiscal year beginning September 1, 2021, including three new state directed payments and one state directed payment that was renamed and expanded in terms of the size of the program. Texas Medicaid officials indicated that the approximately $3 billion increase in state directed payments was intended to substitute for the DSRIP payments which, consistent with the terms of THTQIP, expired after September 30, 2021.

CMS's Initial Response to State Directed Payment Proposals

On August 13, 2021, CMS indicated to Texas that we did not anticipate approving Texas's proposed state directed payments in their current form because we were unable to determine that the proposed payments met all applicable federal statutory and regulatory requirements under the Social Security Act (the Act) and implementing regulations. In that August 13 letter, we described our concerns with the state directed payments, notified the state of specific further modifications required for approval, and indicated CMS's willingness to work with the state to find an approval path. CMS offered two specific options for the state directed payment proposals:

1. CMS **approves** the quality incentive payment program (QIPP) for SFY 2022 as currently submitted and consistent with the payment amounts approved in QIPP for SFY 2021. Texas **will revise** the comprehensive hospital increase reimbursement program (CHIRP) for SFY 2022 to reflect only the uniform hospital rate increase program (UHRIP) payment amounts that were approved in UHRIP for SFY 2021. The **state will withdraw** the Texas incentives for physicians and professional services (TIPPS), rural access to primary and preventative services (RAPPS), and behavioral health services directed payment program (BHS) preprints for SFY 2022. Or
2. The state **modifies all five (5) state directed payment preprints** currently under CMS review for SFY 2022 to be consistent with statutory and regulatory requirements. The state must submit new proposals to describe how it will address the following issues across all five (5) of the state directed payment preprints. Specific concerns related to each of the issues below were described in the August 13 letter:
    - Aggregate Funding Amounts
    - Linking Payments to Current Utilization
    - Quality Improvement
    - Non-Federal Share
    - Evaluation Plan

In addition, CMS acknowledged the importance of a sustainable approach to safety net hospital reimbursement. We recognized Texas's concern about reduced payments to safety net providers that may follow from the expiration of the DSRIP program without approval of the state directed payments the state had intended to replace DSRIP. CMS offered a path to temporarily address that issue while CMS and the state work toward a solution that continues funding for Texas providers while adhering to the Medicaid statute and regulations. To address near-term stability for safety net providers, CMS offered to approve an amendment to the THTQIP demonstration that would extend the DSRIP program for one year (through September 30, 2022) up to an amount necessary to maintain the previous combined funding level, provided Texas first submits an amendment request consistent with the requirements of the special terms and conditions of the THTQIP demonstration.

Ongoing State-CMS Interactions

Texas responded to CMS, initially, on August 16, 2021. In its letter, Texas indicated that it wanted to work with CMS toward approval of the state directed payments and is committed to finding an approach that is consistent with all applicable regulatory and statutory requirements. Texas further indicated it lacked sufficient information from CMS to establish that applicable federal requirements were met at the time.

In a subsequent letter to CMS on September 7, 2021, Texas indicated an interest in working "with CMS to maintain existing payment programs on a temporary basis and achieve agreement on a long-term solution that aligns with the Special Terms and Conditions (STCs) of" THTQIP. Specifically, Texas stated that "HHSC and CMS can act to continue funding through existing programs . . . , while also reaching an enduring agreement on the pending [state directed payments] . . . . HHSC's acceptance of the temporary solutions is conditioned on CMS continuing to meet with Texas to work toward final approval of the pending [state directed payments]." Texas's letter then listed three components of what it would accept. First, Texas indicated that it would accept CMS's offer to extend DSRIP for one year and that it understood such an extension would require Texas to submit an amendment to the THTQIP demonstration before moving forward with such an extension. Second, Texas stated it would accept "CMS's offer to approve the [QIPP] program and temporarily renew the [UHRIP] program." Texas explained that under this component, Texas and CMS would "continue their work, as outlined in the STCs, toward final approval of the four other pending pre-prints." And third, Texas stated it would "accept[] CMS's offer" to "continue meeting with Texas to work collaboratively toward final approval of the pending state directed payments." Texas made clear that this component was "a condition for [Texas] to agree to the temporary solutions for maintaining existing payment programs (as described in 1 and 2 above)."

Although Texas stated in its letter that it was accepting CMS's offers to extend DSRIP and approve QIPP and UHRIP, we note that Texas **did not accept either option** for modifications of its state directed payments that CMS offered in CMS's August letter. Instead, Texas's September 7 letter indicated it wanted *both* to work toward renewal of the two existing state directed payments (UHRIP and QIPP) as outlined in Option 1, and to continue working towards approval of its new and expanded state directed payments as described in Option 2. Texas also stated that its acceptance of CMS's offer to extend DSRIP by one year was conditioned on CMS agreeing to the state's state directed payment proposal as described in points one and two in its letter. Texas did not take the actions CMS described in its August 13 letter that would have been necessary for Texas to accept CMS's offers to approve UHRIP and extend DSRIP by one year. Texas did not revise and resubmit the UHRIP preprint as described in Option 1. And Texas did not submit a demonstration amendment request to extend DSRIP by one year.

Since Texas's September letter, CMS has offered Texas a long-term path that maintains adequate levels of support and sustainability for the health care safety net. This proposed alternative approach is not intended to delay or undermine work to bring all of the state directed payment proposals into compliance with federal requirements, and CMS remains committed to providing technical assistance to the state as described in this letter and its August letter. If Texas is interested in exploring an alternative, however, we have proposed using a range of approaches, including some approvable state directed payments and a Health Equity Pool, grounded in the

state's commitment to report data stratified by race/ethnicity and other factors, improve health outcomes and reduce health disparities. Such approaches would be financed jointly with federal Medicaid funds and non-federal funds that meet all federal statutory and regulatory requirements. We believe the THTQIP section 1115 demonstration and other Medicaid authorities can support such a path and address the state's budget neutrality concerns. If Texas is interested in this alternative, we look forward to continuing to discuss this mechanism for supporting safety net providers, reducing health disparities and improving health outcomes in Texas.

CMS and the Texas Health and Human Services Commission (HHSC) staff have been meeting regularly to address the remaining concerns over Texas's state directed payments. Our teams meet every 2 business days and CMS has worked with the state over the last several months to surface and address issues. Since August, the state has made programmatic changes to all of the underlying state directed payment preprints to address some of the concerns CMS raised in its August letter:

1. Limiting Payment to Current Utilization: The state agreed to reconcile interim payments to actual utilization under the programs.
2. Addressing Concerns related to Quality Improvement: The state agreed to condition payment on quality improvement and ensure attribution of the program to managed care program participants.
3. Addressing Concerns Related to the State's Evaluation Plan: The state agreed to strengthen the evaluation plans for the state directed payments.
4. Addressing Aggregate Funding Amounts: The state provided CMS with a more complete provider reimbursement analysis and offered to limit hospital payments under CHIRP to 90 percent of the average commercial rate, making those payments consistent with our historic policy, reducing the potential for actuarial soundness concerns.

Based on information received from the state on October 22nd, and other information Texas has provided since August, CMS has now determined that two of the state directed payment arrangements (the QIPP and the BHS) appear to meet programmatic and non-federal share financing requirements in section 1903(w) of the Act and implementing regulations in 42 CFR Part 433. As a result, and because the other concerns with these payments were resolved as described above, CMS intends to approve these two state directed payments, which will satisfy the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1).

While we appreciate the collaboration to address the above issues, not all concerns related to the remaining state directed payment requests have been addressed. Specifically, despite multiple requests in our regular meetings and via email exchanges, the state has not provided information necessary (described in the five CMS requests detailed below) for CMS to ensure the state's source of non-federal share for amounts paid to MCOs with respect to three state directed payments (CHIRP, RAPPS and TIPPS) complies with certain health care-related tax requirements in section 1903(w)(4)(C) of the Act and implementing regulations in 42 CFR 433.68(f)(3).

Current Understanding of the Local Provider Participation Fund

CMS understands the Local Provider Payment Fund (LPPF) arrangements to work as described in the third-party materials[1], which is as follows:

- LPPFs collect revenue through hospital taxes imposed by numerous localities in Texas and transfer this revenue to the state Medicaid agency through intergovernmental transfers (IGTs).
- The state uses this revenue as a source of non-federal share of certain Medicaid payments, including proposed payments to taxpaying hospitals under three pending state directed payment arrangements. "Hospitals that have little or no Medicaid volume" or those that do not qualify for relevant Medicaid payments are considered "net loss hospitals" because they "will pay more into the LPPF [through the hospital tax] than they receive in benefit in the form of an increased Medicaid payment."
- "…within 30 days" of paying its hospital tax, each net loss hospital receives a redistribution payment from hospitals that benefit from increased Medicaid payments in an amount "generally equal to 105 percent of the amount" of the total tax cost of the net loss hospital.
- The third-party materials also state, "The LPPF only works if everyone that is subject to the fee [the hospital tax] ends up with a benefit."

Federal Financial Participation (FFP) is not available for Medicaid programs where the state's share of the Medicaid payments for those programs are financed through health care-related taxes and there is a "hold harmless arrangement" in place. As applicable here, hold harmless arrangements, as described in section 1903(w)(4)(C) of the Act, exist where the "State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." Based on information obtained by CMS, including limited information provided by the state and publicly available third-party materials[2], the LPPF arrangements used by some localities in Texas appear to include hold harmless arrangements because the localities impose a tax and the state directly or indirectly provides for payments that guarantee to hold the taxpayers harmless for all or any portion of the tax amount. If our understanding of those LPPF arrangements is correct, they constitute hold harmless arrangements that are prohibited under section 1903(w)(4) of the Act and CMS's regulations and as described in the preamble to our 2008 final rule.

Information Requests Related to LPPF Arrangements

Despite numerous requests, the state has not provided the information needed to determine whether the LPPF arrangements used to fund some of Texas's requested state directed payments meet federal requirements. With only very limited information from the state on the LPPF arrangements, CMS has relied on publicly available third-party materials[3] for more complete information about the arrangements. CMS has previously shared with the state this third-party description of the arrangement. Texas has not denied that the information provided in those materials is an accurate description of how the LPPFs operate in Texas or provided any

[1] https://lonestarhfma.org/wp-content/uploads/2015/06/170801-David-Salsberry.pdf
[2] ibid
[3] ibid

information to CMS that refutes the third-party description as representative of the LPPF arrangements in the state.

Instead, the state has indicated it is aware of the existence of such agreements among at least some LPPF-participating providers. By its own statements, dating back to December 2018, the state has been aware that agreements among providers relating to the LPPF may exist. The state acknowledged that it obtained this information through direct conversations with a consultant and through CMS providing the third-party information described above.

As previously requested in our regular meetings and via email exchanges, we request the state to respond to the five requests below in writing. We are seeking a clearer understanding of the specifics of the redistribution aspect of the LPPF arrangements, and for copies of any agreements that might be in place.

If the hold harmless arrangements described above do not exist or if Texas has already taken measures to end those arrangements, please provide the following information to demonstrate that the state's non-federal share sources comply with section 1903(w)(4) of the Act and 42 C.F.R. § 433.68(f)(3):

1. A comprehensive description of how the LPPF arrangements work, including at the provider level.
2. Copies of mitigation agreements or similar agreements in place between or among LPPF-participating providers and/or the LPPF and a complete description of how the LPPF mitigation arrangements work, including at the provider level.
3. As an alternative to providing the agreements in #2, attestations from each participating provider or from the state (attesting on behalf of each provider) that the providers do not participate in arrangements, through written agreements or otherwise (including non-written agreements or understandings that result in reasonable expectations for participating parties), which involve participating providers transferring, redirecting, redistributing (irrespective of state or local government involvement) Medicaid or other payments to other providers, directly or indirectly (irrespective of whether the state or units of local government are compelling or sanctioning provider participation).
4. If all participating providers or the state are able to provide the attestation(s) in #3, a comprehensive description of the process used by the state and providers to ensure the accuracy of the attestation(s) that the arrangements described in #3 have either stopped or were never in effect.
5. Confirmation that no locality, including Ellis and McClennan Counties, imposes a health care-related tax in which all taxpaying hospitals receive at least their total tax cost back in the form of Medicaid payments or other payments.

Although the state has explicitly acknowledged in an October 22, 2021 email to CMS that the agreements exist among providers, it has indicated to us that it "has not reviewed, approved, or sanctioned any such agreements or arrangements, and does not intend to." The statute and implementing regulations prohibit hold harmless arrangements without consideration of whether the state has "reviewed, approved or sanctioned" them. As described above, LPPF-participating parties reasonably expect that taxpaying hospitals are held harmless for all or a portion of the tax. Accordingly, based on the publicly available information suggesting such hold-harmless

arrangements exist and Texas's admission that they exist, we reasonably believe that impermissible hold-harmless arrangements exist in Texas in connection with the LPPFs.

We have repeatedly provided the state an opportunity to demonstrate that the hold harmless arrangements described are not in place or have ended, including through attestations from the state or participating providers. These attestations are not required by law, but we have offered them as a way for the state to demonstrate that it satisfies the requirements for Medicaid payments under section 1903(w)(4). We are permitting Texas to demonstrate its compliance through attestations, to allow Texas and CMS to avoid the more resource-intensive, back-end investigations into exactly how the LPPF arrangements work in each locality. So far, the state has only offered us a limited assurance that covers units of government and does not cover any private providers that participate in LPPF arrangements, including those that receive Medicaid payments.

Next Steps

CMS is committed to working with states to support safety net providers and to ensure that safety net financing and reimbursement approaches advance measurement and accountability for improving health equity and quality. We are also committed to following all applicable federal statutory and regulatory requirements, including requirements that are essential to the fiscal integrity of the Medicaid program. To that end, we are providing Texas with one more opportunity to demonstrate that its source of non-federal share for these arrangements meets federal statutory and regulatory requirements. Please provide CMS with this information, as described in the list above, within 14 calendar days from the receipt of this letter. If the state believes that collecting this information may take longer than 14 calendar days, please notify us within 14 days from receipt of this letter of the date by which Texas will deliver the information requested.

As we have discussed, CMS remains committed to a path to long-term sustainability for the health care safety net in Texas. We remain committed to working collaboratively with Texas toward approval of Texas's state directed payments, provided Texas is willing to provide the information and make the necessary changes we have outlined above. In addition, if Texas wishes to pursue an extension of DSRIP until September 30, 2022, up to an amount necessary to maintain the SFY 2021 combined funding level of DSRIP and state directed payments, CMS remains open to that application, consistent with the terms of the amendment process described in the THTQIP demonstration.

We have alternatively proposed a compromise that, using a range of approaches, including approvable state directed payments and a Health Equity Pool, financed jointly with federal Medicaid funds and non-federal funds, we believe would meet all federal statutory and regulatory requirements. We believe the section 1115 demonstration and its budget neutrality model can support such a Health Equity Pool, and we look forward to continuing to discuss this mechanism for supporting safety net providers, reducing health disparities and improving health outcomes in Texas. CMS recognizes the complexity of the financing issues in the Texas Medicaid program. We understand the importance of addressing these issues in a way that meets the needs of multiple stakeholders, ensures confidence in the fiscal integrity of Texas's Medicaid

program, and sustains and improves access to and quality of healthcare. CMS is committed to partnering with Texas to address these issues.

We remain available to provide technical assistance regarding both payment approaches and replacing or modifying sources of non-federal share. For example, CMS could provide the state detailed technical assistance on options available to restructure its existing health care-related taxes, including through possible waivers of the statutory broad-based and uniformity tax requirements. This approach could ensure that the state's non-federal share sources both meet statutory and regulatory requirements and consider HHSC's programmatic goals.

CMS remains committed to working with Texas to ensure a high quality, sustainable health safety net. If you have questions, please contact me or Rory Howe, Director, Financial Management Group at (410) 786-4878.

Sincerely

[redacted]

Daniel Tsai
Deputy Administrator and Director