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Our inquiries lead us to conclude that the $72,633,689 deferral should be withdrawn.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

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[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.

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

III. There Was No Impermissible Redirection of Funds.

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

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

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

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

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

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

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

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

IV. Other issues

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

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

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

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

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

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

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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,

/s/

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

Attachment 1

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

CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid & Children's Health, Region VI

Date: November 8, 2007

To: Kevin Nolting, HHSC

CC: Chris Traylor, HHSC; James Frizzera, CMS; Bill Brooks, CMS; Lynn Ward, CMS; Dorothy Ferguson, CMS

From: Billy Bob Farrell, CMS

Subject: Texas Private UPL review issues

As promised, the following includes, but is not limited to, a list of the issues to date that have arisen as a result of the financial management review of the Texas private hospital upper payment limit (UPL) program. Please be advised that this list is not meant to represent CMS's final determination with respect to our review of the Texas private hospital UPL program. Instead, this list merely identifies initial areas of concern.

1. Recoupement of funds--Certain participating private hospitals returned to local governments the funds they received for providing indigent care services during 2005 and 2006 that were then used as the non-Federal share of private hospital UPL payments.

2. Compensation by provision of local governments "needs"-- Compensation by provision of local governments "needs"--affiliated hospitals purchase items for the local government (i.e. purchase of capital equipment or assumption of local government contractual obligations). –another form of a non-bona fide provider-related donation to the local governments by the private hospitals.

3. Management or administration fees--Local governments are being paid a management or administration fee to manage the local indigent care programs. These fees are usually based on a percentage of the private hospital UPL program payments –a redirection of the Medicaid payment.

4. Contingency fees to consultants—Consultants are contracted with affiliated private hospitals to receive up to 3.5% contingency fees for legal and consulting services relative to the private UPL program. –a redirection of the Medicaid payment

5. Escrow representative agreements and district representative agreements--Some of the escrow and district representative agreements include compensation for those representatives (banking, consultants, or local government entities), usually on a percentage or contingency basis. –a redirection of the Medicaid payment.

6. **Transferring of FFP after payment**-- Several examples of executed documents that have been obtained in the review (i.e. needs analysis, district representative agreements) are significantly different than model documents supplied to CMS by consultants. These documents indicate that private hospitals in the affiliated group are transferring a portion of their UPL payments to other private hospitals in the affiliated group. This is sometimes due to the private hospitals in the group compensating the publics for actual indigent care. In other instances private hospitals are providing transfers 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. – a redirection of the Medicaid payment

7. **Calculating payments based on unallowable service charges**— For purposes of calculating an inpatient hospital upper payment limit (UPL), under state plan provisions, only inpatient hospital charges/data may be used in the UPL demonstration. However, the 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.

8. **No changes in the provision of Medicaid or indigent care**—Private hospitals are receiving Medicaid supplemental funding but do not actually provide or expand Medicaid or indigent care under the program. Most of the contractual documents require a commitment by the private hospitals to "provide indigent care". What actually happens is that the public/safety net hospitals (sometimes the hospital districts that are funding the IGT's for the private 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.

9. **Using alternative funds for IGT's**— Some local governmental entities are obtaining loans or letters of credit to fund the IGT's rather than using their own tax dollars—federal guidelines and the Texas State Plan require the use of ad valorem tax dollars for intergovernmental transfers.

10. **Some of the private affiliates are not hospitals**—Some 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. These facilities are owned by national corporations. Hospital UPL is not available to these entities.—this procedure is outside of the state plan provisions

The review is by no means complete; therefore, we could very possibly add further issues to the list.

Please contact Lynn Ward at 512-491-1401 or me at 214-767-6407 with any questions or concerns.

Billy Bob Farrell

Billy Bob Farrell