DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

December 13, 2021

Stephanie Stephens
State Medicaid Director
Health and Human Services Commission
Mail Code: H100
Post Office Box 13247
Austin, Texas 78711

RE: State Plan Amendment 21-0036

Ms. Stephens:

We have completed our review of the proposed amendment submitted under transmittal number (TN) 21-0036. This plan amendment has an effective date of October 1, 2021 and was submitted in order to create a Hospital Augmented Reimbursement Program for private hospitals to preserve the financial resources many Texas hospitals depend on to provide access and quality care to Medicaid clients.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of Federal Financial Participation (FFP) and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions/concerns regarding TN 21-0036:

Intergovernmental Transfers (IGTs)

1. It appears an intergovernmental transfer (IGT) will be used as the state match as defined in 42 CFR 433.51 public funds as the state share of financial participation. CMS needs to determine if this IGT is permissible.

   § 433.51 Public Funds as the State share of financial participation.

   (a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

"Non-state government-owned and operated hospitals participating in the Texas Medicaid program that meet the conditions of participation and serve fee-for-service patients are eligible for reimbursement. The non-federal share of the payments is funded through intergovernmental transfer (IGT). The Health and Human Services Commission (HHSC) will establish each hospital's eligibility for an amount of reimbursement using the methodology described in this appendix."

a. Please provide a list of hospital that will participate in this program along with the amount each eligible hospital is expected to receive.

b. Please clarify how HHSC determines each hospitals eligibility for reimbursement

c. Please provide an IGT agreement between the state

"Non-federal share of program payments. The non-federal share of the payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the program."

a. Please provide a list of all sponsoring governmental entities along with agreements in place between the entities and the state.
b. Please provide agreements in place between the hospitals and the sponsoring entity
c. Please provide agreements between the HHSC and the participating hospitals.
d. Please provide a list of sponsoring entities expected payment amounts to fund the IGT.
e. Please provide an IGT agreement between the state and the sponsoring entity.

"*A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a hospital's payment amount calculated under this subsection, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal"*
share transferred.

a. Please provide CMS a list of the single government entities that will be providing the non-federal share of the payments.
b. Please provide copies of agreements in place between the single local governmental entity and HHSC.
c. Please provide copies of agreements in place between the single local governmental entity and private participating hospital.
d. 42 CFR 443.53 (c) (2) states if there is local financial participation, lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the State. Please explain and align the state plan to follow the regulation.

"HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities."

a. Please provide IGT responsibilities determined by HHSC.
b. Please provide amounts of estimated revenues each hospital will receive.

"Payments under this section will be made on a semi-annual basis."

a. When will the payments, on a semi-annual basis, be made?

Efficiency, Economy, and Quality of Care

2. SPA amendment TX#21-0036 proposes to establish a Hospital Augmented Reimbursement Program (HARP) for privately owned and operated hospitals comes from IGTs. Section 1902(a)(30)(A) of the Act requires that payment rates must be consistent with "efficiency, economy and quality of care." Please justify how the establishment of payments is consistent with the principles of "efficiency, economy, and quality of care."

Response: The program is for private providers and totals $846,748,794 in FY2022. This program helps preserve the financial resources many of our hospitals depend on to provide access to quality care to Medicaid clients and the uninsured.

a. How are these programs currently funded, if this is to preserve financial resources?
b. Why are current programs that perform this funding source being changed to the HARP reimbursement program?
c. Please explain how this is an efficient use of Medicaid funds.

Upper Payment Limit (UPL)

3. Regulations at 42 CFR 447.272 require that payments in the aggregate will not exceed a reasonable estimate of what Medicare would pay for similar services.

Please provide an UPL demonstration applicable to the payments for the future rate period (i.e. SFY 2022) for the hospitals. Please note that we cannot move forward with any State plan amendment approvals until the UPL demonstration is in final form. The inpatient hospital UPL demonstration must be formally submitted to the UPL mailbox using the approved OMB template.

The templates, guidance, and FAQs are located at UPL Website. (This is a hyperlink to that site.) The UPL mailbox is MedicaidUPL@cms.hhs.gov.

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material, which would have expired on December 13, 2021. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, and subsequently reiterated in the August 16, 2018 Center for Medicaid and CHIP Services Informational Bulletin, if a response to a formal request for additional information from CMS is not received from the state within 90 days of issuance, CMS will initiate disapproval of the SPA or waiver action. In addition, because this amendment was submitted after January 2, 2001

and is effective after January 1, 2001, please be advised that we will defer federal financial participation (FFP) for state payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

We ask that you respond to this RAI via the Dallas Regional Office SPA/Waiver e-mail address at CMS SPA_Waivers_Dallas_R06. The original signed response should also be sent to the Dallas Regional Office.

If you have any questions, please feel free to contact Tom Caughey at 517-487-8598 or via email at Tom.caughey@cms.hhs.gov

Respectfully,

Todd McMillion

Todd McMillion
Director
Division of Reimbursement Review