Texas Hospital Association

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Via electronic submission to PFD_LFM@hhs.texas.gov

Ms. Frances Morgan
Director of PFD Local Funds Monitoring
Texas Health and Human Services Commission
4601 Guadalupe Street, Mail Code H400
Austin, TX 78751

Re: Proposed Rule 22R041 Concerning Monitoring of Local Funds in the Medicaid Program

Dear Ms. Morgan:

On behalf our nearly 500 member hospitals and systems, Texas Hospital Association (THA) appreciates the opportunity to submit comments on proposed new Subchapter L comprised of §355.8701 - §355.8706 concerning monitoring of local funds in the Texas Medicaid program.

THA understands the purpose of the proposed rule is to implement the requirements of the 2022-2023 General Appropriations Act, HHSC Rider 15(b), Senate Bill 1, 87th Legislature, and to comply with federal regulations related to use of permissible sources of funding for the nonfederal share of Medicaid payments. Through this effort, HHSC will be better equipped to administer Medicaid payment programs and respond to federal Centers for Medicare and Medicaid Services (CMS) questions regarding Texas' methods of finance. We hope these measures will contribute to resolution of the impasse in state-federal negotiations on three directed payment programs that have been delayed six months, totaling more than $5 billion annually in suspended supplemental funding to Medicaid providers in Texas.

At the same time, how new reporting and monitoring processes are applied makes a great difference to our members. In 2020, Texas hospitals joined provider groups and state Medicaid directors nationwide in opposing CMS's proposed Medicaid Fiscal Accountability Regulation (MFAR) in part because it threatened to limit acceptable sources of intergovernmental transfer (IGT) and impose undue burdens on states, local government entities, and providers participating in compliant health care-related funding mechanisms. As you are aware, MFAR was withdrawn in 2021 under the weight of these substantial concerns.

Similarly, hospitals' comfort with HHSC's proposed process for monitoring local funds hinges upon how HHSC or CMS will use the information governmental entity funding sources are reporting. Hospitals have long supported transparency in local funds used for Medicaid finance. We appreciate that HHSC's stated intent is to demonstrate permissibility of Texas' existing funding sources more readily, not to replicate MFAR. **However, hospitals would have reservations about any rule that could give way to outcomes resembling MFAR in practice.** Our recommendations and questions highlight areas where more clarity, boundaries, and stakeholder input should be incorporated to avoid such an outcome and keep Texas' Medicaid finance system intact.

Recommendations

Consider ways to limit administrative burden and prevent unintended consequences.
Sec. 355.8704 describes the types of documentation HHSC will be collecting and how HHSC will use the information collected to determine likelihood of permissibility of funds for use in the Medicaid program. We believe the process can be both thorough for purposes of demonstrating compliance and constrained to reduce administrative burden on reporting entities. HHSC's collection of debt instruments, patient revenue, payor mix, budget revenue received from all sources, and "other information as determined necessary and appropriate" causes concern as it is very broad and not limited to just the IGT, and there is not a clear rationale for collecting the data elements described in the rule.

Sec. 355.8704(h) indicates HHSC may consult with CMS on compliance of specific funding sources, implying CMS will have visibility into information collected. As we have seen recently during negotiations on pending directed payment programs and in other instances where CMS has questioned the permissibility of local financing arrangements, CMS may, with the same information, reach a different determination than the state on likely permissibility of funds. HHSC has disputed CMS's current position that nonfederal Medicaid funds derived from LPPFs are impermissible as "unreasonable and unsupported," and we agree.

With awareness of CMS's current policy approach to Texas' LPPF-financed Medicaid programs, information supplied in this process must not exceed the scope of what state and federal law require and should contribute to resolution of CMS's existing concerns. We cannot help but be wary of submitting other information that could be used by CMS to continue to pursue unreasonable and unsupported positions that limit acceptable sources of IGT. Hospitals share CMS and HHSC's goal of increasing transparency in Medicaid and welcome opportunities to demonstrate compliance. At the same time, we would be reticent to share information that could be used subjectively at the federal level to reinforce a policy agenda that undermines our state's already fragile health care safety net.

> ***Recommendation #1:*** *We recommend HHSC convene a task group of stakeholders to develop the information requests and survey form. This process will ensure each required element is tied to a clear compliance purpose, streamline collection of information, and limit unnecessary or open-ended requests.*

Distinguish between reported information and electronic survey, identify required elements, and clarify survey terms.
Sec. 355.8704(a)-(c) references "information" governmental entities must report to HHSC in a form and format to be determined. Sec. 355.8704(d)(1) states that HHSC will use information from the report in monitoring efforts, which will include an electronic survey.

"Information" is not defined or described in (a)-(c). As written, it is not clear what distinguishes the practice of reporting information to HHSC from completing a separate electronic survey in (d)(1). Without further clarification, these processes appear duplicative. HHSC should clarify that the survey in (d)(1) is intended to be a distinct information request from the report described in (a)-(c), or otherwise eliminate the potentially duplicative information requests.

If different from the survey, the rule ought to specifically describe what information will be contained in the initial report of information in (a)-(c), as entities must report this information. Clarification on this point is essential because 355.8704(e) states that "if any entity fails to submit *the required information* [emphasis added]…HHSC will not accept further transfer of funds for any Medicaid program from the governmental entity until the reporting requirement is satisfied." Governmental entities will also need to understand this element of rule better to gauge the administrative burden these reporting requirements are likely to create.

Subsection (d)(1) lists information the survey will "request." Unlike subsection (a), which states governmental entities must report information, the term "request" implies governmental entities may voluntarily furnish information but are not compelled to provide any or all components. We ask HHSC to revise this section to identify what, if any, survey components are subject to required reporting to avoid any unanticipated or unintended compliance issues.

Finally, the term "budget revenue" in Sec. 355.8704(d)(1)(G) is unclear. We request a definition be added.

> ***Recommendation #2:*** *We urge HHSC to eliminate duplicative information requests.*
> ***Recommendation #3:*** *We urge HHSC to identify all required reporting elements throughout Sec. 355.8704.*
> ***Recommendation #4:*** *Please define what is meant by the term "budget revenue" in Sec. 355.8704(d)(1)(G).*

Account for regional IGT pooling arrangements in rule text.
Sec. 355.8704(d)(1)(A) states the survey will request a list of all health care providers for which the governmental entity transferred or certified funds as the non-federal share. This component appears not to account for regional IGT pooling arrangements. Every extant or proposed supplemental or directed payment program that includes private entities requires the non-federal share to be pooled somehow, such as at the service delivery area (SDA) level. A governmental entity therefore provides the nonfederal share for all providers in an SDA, not a select subset of providers.

> ***Recommendation #5:*** *Please revise the survey to reflect pooled IGT arrangements.*

Exempt DSH as appropriate from information gathering.
The second phase of applicability in Sec. 355.8703, beginning Oct. 1, 2022, incorporates the Disproportionate Share Hospital (DSH) program. To address the survey requests in Sec. 355.8704(d)(1)(A)-(B), large public DSH transferring hospitals would appear to be required to list every private hospital that participates in DSH, describe their relationship with that private hospital, and furnish copies of contracts even if not related to the nonfederal share of DSH. If this interpretation is correct, such a requirement would be excessive and burdensome.

> ***Recommendation #6:*** *We request exempting DSH from any sections of rule that would require transferring public hospitals to account for relationships or transfers concerning all other DSH participants.*

Narrow the scope of reportable transfers of funds or provisions of services to those relevant to the nonfederal share of Medicaid payments.
Sec. 355.8704(d)(1)(G) indicates HHSC will be requesting information on transfers of funds or provisions of services from a health care provider or related entity to the governmental entity, including cash, in-kind donations, or other transfers of value. Governmental entities and health care providers can often have contracts and agreements requiring transfers of funds or provisions of services, in addition to other transfers of value. Without speaking to every agreement, these transfers may have no relationship to any transfers of the nonfederal share of Medicaid payments. To report on all such agreements is unnecessary and burdensome and falls outside the scope of what is necessary to determine whether a source of nonfederal share is permissible.

> ***Recommendation #7****: We request that the scope of transfers of funds or services contemplated in the survey be narrowed to exclude those with no relationship to the nonfederal share of Medicaid payments.*

Reconsider color categorization system of funding source compliance and differentiate it from the scoring system.
Sec. 355.8704(d)(2) describes the process HHSC will use to classify the risk of certain local funds. It calls for funding sources to receive a risk assessment score based on survey responses and a category label of red, yellow, or green based on whether the funds appear to comply with federal and state statutes and regulations.

The rule does not provide detail on what is intended to be measured by a funding source's risk assessment score or how it is materially different from the color category. Can HHSC clarify, are these two rating methods intended to communicate different information? Would HHSC take different actions based on a funding source's risk assessment score versus its color code? Please differentiate the risk assessment score from the color category.

Further, we are concerned about the color categorization scheme described in Sec. 355.8704(d)(2)(B) wherein funds receiving a green rating appear clearly compliant, funds receiving a yellow rating are not clearly compliant, and funds receiving a red rating do not appear compliant. Attaching these labels to funding sources when the rule does not contain clear, objective criteria for assigning color grades nor a process to remediate a red or yellow label is arbitrary.

As an alternative, we recommend HHSC adopt a binary rating scheme of "compliant" or "needs more information." "Needs more information" is familiar language and more clearly describes the next steps prompted in rule, which are the same for red and yellow sources. These include requests for additional information, examination of supporting documents and potential on-site review.

In 355.8704(d)(2)(B)(i)-(iii), we also recommend replacing the term "arrangement" with "funding source." There is often no arrangement when governmental entities provide nonfederal share for health care providers, regardless of any relationship.

> ***Recommendation #8:*** *Please distinguish the rating system (currently color coded) from the proposed risk assessment score.*
> ***Recommendation #9:*** *We recommend HHSC adopt a binary rating scheme of "compliant" or "needs more information" instead of the color-coded rating system proposed.*

Recommendation #10: *Please replace the term "arrangement" with "funding source" in the rating system.*

Consider whether health care providers have standing as interested parties in post-determination review. Sec. 355.8705 describes the process for an informal administrative review of agency determinations of reporting compliance, permissibility of funds, and risk assessment categories assigned to each funding source. Sec. 355.8705(a) permits an interested party who disputes a determination to request a post-determination review. Interested party is defined as a governmental entity that has non-federal share funds under review.

Recommendation #11: *We recommend HHSC add health care providers who would be harmed by a determination against a governmental entity to those who have standing to be considered an interested party, and broadening the definition of interested party accordingly.*

Thank you for your consideration of these comments. Should you have any questions, please do not hesitate to contact me at astelter@tha.org or 512-465-1556.

Respectfully submitted,

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Texas Hospital Association