

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TEXAS RELIED ON IMPERMISSIBLE PROVIDER-RELATED DONATIONS TO FUND THE STATE SHARE OF THE MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

Inquiries about this report may be addressed to the Office of Public Affairs at
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Christi A. Grimm
Principal
Deputy Inspector General

August 2020
A-06-17-09002

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: August 2020

Report No. A-06-17-09002

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Delivery System Reform Incentive Payment (DSRIP) Program payments are incentive payments made to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and increase the health of patients and families served. These incentive payments have significantly increased funding to providers for their efforts related to the quality of services. Texas made DSRIP Program payments totaling almost \$10 billion for 5 years.

Our objective was to determine whether Texas used permissible funds as the State share of DSRIP Program payments.

How OIG Did This Audit

Our audit covered \$189.3 million in funds used as the State share of \$445.9 million in total DSRIP Program payments made to three providers for December 12, 2011, through September 30, 2016. We traced the flow of DSRIP-related transactions to financial records, compared contracts that an intergovernmental transfer (IGT) entity managed to the same contracts assumed by one of the providers, and calculated the Federal share that Texas received because of impermissible provider-related donations.

Texas Relied on Impermissible Provider-Related Donations To Fund the State Share of the Medicaid Delivery System Reform Incentive Payment Program

What OIG Found

Of the \$189.3 million in funds that Texas used as the State share of DSRIP Program payments, \$146.6 million was funded through impermissible provider-related donations that did not meet Federal requirements. Those funds were derived from impermissible provider-related donations because:

- the providers made donations that benefited the IGT entity,
- the funds the IGT entity transferred resulted from those donations, and
- the providers' donations were part of a hold-harmless practice.

Texas did not decrease its Medicaid expenditures by the \$146.6 million as required under Federal requirements. As a result, Texas inappropriately received \$83.8 million in Federal funds.

What OIG Recommends and Texas' Comments

We recommend that Texas: (1) refund the \$83.8 million it inappropriately received because it used IGTs derived from impermissible provider-related donations as the State share of DSRIP Program payments; (2) provide its IGT entities with guidance about arrangements that may result in impermissible provider-related donations, such as those outlined in the Centers for Medicare & Medicaid Services' (CMS's) clarifying letter; and (3) request that its IGT entities disclose whether similar arrangements exist and provide Texas with action plans on ending the arrangements.

Texas concurred with our third recommendation to the extent that it contemplates identifying arrangements that resemble those outlined in a Departmental Appeals Board decision and provided information on actions it had taken related to that recommendation. Texas did not concur with our first and second recommendations because of the reliance we placed on CMS and judicial determinations, which are currently under appeal by Texas. After review and consideration of Texas' comments, we maintain that our finding and recommendations are valid because Texas' impermissible provider-related donations were in violation of Federal regulations that applied during the audit period.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit	1
Objective	1
Background	1
Medicaid Program.....	1
Texas' Medicaid Delivery System Reform Incentive Payment Program.....	2
Federal Requirements for Provider-Related Donations	3
How We Conducted This Audit	4
FINDING.....	5
The State Agency Relied on Impermissible Provider-Related Donations To Fund the Majority of the State Share of Payments.....	5
Indirect Provider-Related Donations Benefited Central Health	5
The Funds Central Health Transferred Resulted From Provider-Related Donations.....	6
The Donations Were Part of a Hold-Harmless Practice.....	7
CONCLUSION AND RECOMMENDATIONS	8
STATE AGENCY COMMENTS	9
OFFICE OF INSPECTOR GENERAL RESPONSE	10
APPENDICES	
A: Audit Scope and Methodology	12
B: State Agency Comments.....	14

INTRODUCTION

WHY WE DID THIS AUDIT

Under Texas' section 1115 waiver,¹ incentive payments made to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and improve the health of patients and families served are made through the Delivery System Reform Incentive Payment (DSRIP) Program. DSRIP Program payments are not direct reimbursement for expenditures or payments for services. Incentivizing improvements to providers' health care delivery systems is a relatively new practice in Texas. These incentive payments have significantly increased funding to providers for their efforts related to the quality of services. Texas made DSRIP Program payments totaling almost \$10 billion for demonstration years 1 through 5.

States may use funds transferred from another government entity (such as a county, city, or another State agency) to fund the State share of Medicaid expenditures if the funds are permissible under Federal requirements.

OBJECTIVE

The objective of our audit was to determine whether the Texas Health and Human Services Commission (State agency) used permissible funds as the State share of DSRIP Program payments.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. In Texas, the State agency administers the Medicaid program. Although the State agency has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Federal Government pays its share of a State's Medicaid expenditures based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. The State is responsible for funding the remainder of its expenditures, or the State share.

¹ Section 1115 of the Social Security Act (the Act) gives the Secretary of Health and Human Services (the Secretary) the authority to approve experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. Texas' waiver was effective December 12, 2011.

In the 1980s, States began seeking alternative mechanisms to finance the State share of rising Medicaid expenditures. One such mechanism was the use of provider-related donations. Providers would make a donation to the State, which would then use the money as the State share of Medicaid payments and receive Federal matching funds. States would generally increase Medicaid payments to providers for Medicaid services to reimburse the providers for their donations and use the Federal matching funds. As a result, providers generally received back their donations in Medicaid payments, and Federal expenditures increased without any corresponding increase in State expenditures. To address this issue, Congress enacted the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (P.L. No. 102-234), which amended the Act to limit States' use of funds derived from certain provider-related donations to finance the State share of Medicaid expenditures.

States may use funds transferred from another government entity (such as a county, city, or another State agency) to fund the State share of Medicaid expenditures. These intergovernmental transfers (IGTs) may be funded with permissible provider-related donations.

States report expenditures and the associated Federal share on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The amounts that States report must represent actual expenditures.

Texas' Medicaid Delivery System Reform Incentive Payment Program

The DSRIP Program provides incentive payments that the State agency makes to hospitals and other types of providers. The DSRIP Program operates as part of Texas' section 1115 waiver. The waiver states that DSRIP Program payments are available for the development of a program that supports hospitals' efforts to enhance access to health care, increase the quality of care, and improve the health of the patients and families they serve.

The waiver established 20 regional health care partnerships (RHPs) throughout Texas. Under these RHPs, providers are grouped together within the same geographic boundary. Each RHP is anchored by a public hospital or local government entity, which financially supports the DSRIP Program within its geographic boundaries and has the authority to make IGTs.

The Travis County Healthcare District, doing business as Central Health, anchors the Region 7 RHP, which encompasses Bastrop, Caldwell, Fayette, Hays, Lee, and Travis Counties. As the RHP 7 anchor entity, Central Health controlled the level of DSRIP Program payments that an RHP 7 provider could receive. Additionally, Central Health was also an IGT entity and transferred funds for the State share of some RHP 7 providers' DSRIP Program payments. Within RHP 7, two entities received the majority of DSRIP Program payments: the Community Care Collaborative (CCC) and the Seton Healthcare Family (Seton).

Central Health and Seton, a private hospital chain, established CCC, a 501(c)(3) nonprofit corporation, in 2013 to provide a framework for implementing Texas' waiver and an integrated delivery system for the uninsured and underinsured populations of Travis County. Central

Health and Seton co-own CCC. For Federal fiscal years (FYs) 2013 through 2017,² Seton provided \$169 million in financial support to CCC, and Central Health provided \$87.6 million. Central Health transferred the funds used to cover the State share of all DSRIP Program payments that the State agency made to CCC and to two Seton hospitals.

Federal Requirements for Provider-Related Donations

The Act requires a State to reduce its Medicaid medical assistance expenditures by provider-related donations it received either in cash or in kind, unless the donations are bona fide. A provider-related donation is bona fide when it has no direct or indirect relationship to Medicaid payments to the provider, providers furnishing the same class of items and services as the provider, or any entity related to the provider. The Secretary may specify the types of donations that will be considered bona fide provider-related donations.³

Federal regulations state that CMS will deduct impermissible provider-related donations from a State's expenditures for medical assistance before calculating the Federal Financial Participation (FFP). The only permissible provider-related donations are those that constitute bona fide donations, which have no direct or indirect relationship to Medicaid payments made to the donating provider or any related entity, or other providers furnishing the same class of items or services as the provider or entity.

For donations to have no direct or indirect relationship to Medicaid payments, the donations must not be returned to the provider or a related entity under a "hold harmless" provision or practice. Such a provision or practice exists if any of three tests applies, one of which is the guarantee test. The guarantee test is met if the State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver that directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation).⁴

On May 9, 2014, CMS issued a State Medicaid Director Letter (SMDL 14-004) that offered guidance on the statutory and regulatory restrictions on the use of provider-related donations to finance Medicaid payments. The letter explains that public-private partnerships in which "private entities provide a governmental entity with funds or other consideration and receive in return additional Medicaid payments" would not be considered bona fide provider-related donations, and therefore the resulting expenditures would not be allowable for FFP purposes. That prohibition would preclude partnerships in which the funds for IGTs are derived from the private entity taking over the expenditures for a service previously paid for by the public entity.

² October 1, 2012, through September 30, 2017.

³ The Act § 1903(w).

⁴ 42 CFR § 433.54.

In Decision No. 2886, dated August 7, 2018, the Departmental Appeals Board (DAB) upheld CMS's disallowance of \$25.3 million in Federal funds Texas received related to certain private hospitals' Medicaid payments.⁵ CMS disallowed the Federal funds because the State share of the payments was derived from impermissible provider-related donations in the form of private hospitals (through entities they created and owned) undertaking contracts to provide physician services in two public county hospital districts.⁶ Specifically, DAB concluded that:

- the hospitals made indirect provider-related donations that benefited the county hospital districts,
- the funds the county hospital districts transferred to the State agency resulted from the provider-related donations, and
- the hospitals' donations were part of a hold-harmless practice.⁷

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$189.3 million in funds used as the State share of \$445.9 million (\$244.6 million in payments to CCC and \$201.3 million in payments to Seton) in total DSRIP Program payments made to CCC and Seton hospitals for December 12, 2011, through September 30, 2016 (i.e., waiver demonstration years 1 through 5), which the State agency paid and claimed during FYs 2013 through 2017. We traced the flow of DSRIP-related transactions to Central Health's and CCC's financial records and compared provider and administrative contracts that Central Health managed to the contracts between CCC and the same parties.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology.

⁵ On October 2, 2019, DAB declined a request the State agency made for reconsideration of DAB No. 2886. On December 2, 2019, the State agency filed a civil action in Federal court seeking judicial reversal of DAB No. 2886.

⁶ DAB No. 2886, pages 1 and 17.

⁷ DAB No. 2886, pages 17, 21, and 22.

FINDING

In accordance with section 1903(w)(6) of the Act, States are generally prohibited from using IGTs as the State share of Medicaid expenditures if the transferred funds are derived from impermissible provider-related donations. Of the \$189.3 million in funds that the State agency used as the State share of DSRIP Program payments made to CCC and Seton hospitals, \$146.6 million was funded through impermissible provider-related donations. Central Health transferred the \$146.6 million to cover the State share of DSRIP Program payments after CMS issued its letter that offered guidance on the use of provider-related donations to finance Medicaid payments. Those funds were derived from impermissible provider-related donations because:

- CCC and Seton made donations that benefited Central Health,
- the funds that Central Health transferred to the State agency resulted from those donations, and
- CCC's and Seton's donations were part of a hold-harmless practice.

The State agency did not provide its IGT entities with guidance about the arrangements outlined in CMS's clarifying letter that may result in impermissible provider-related donations. The State agency did not decrease its Medicaid expenditures by \$146.6 million as required by Federal requirements. As a result, the State agency inappropriately received \$83.8 million in Federal funds.⁸

THE STATE AGENCY RELIED ON IMPERMISSIBLE PROVIDER-RELATED DONATIONS TO FUND THE MAJORITY OF THE STATE SHARE OF PAYMENTS

Indirect Provider-Related Donations Benefited Central Health

A provider-related donation is a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider or related entity.⁹

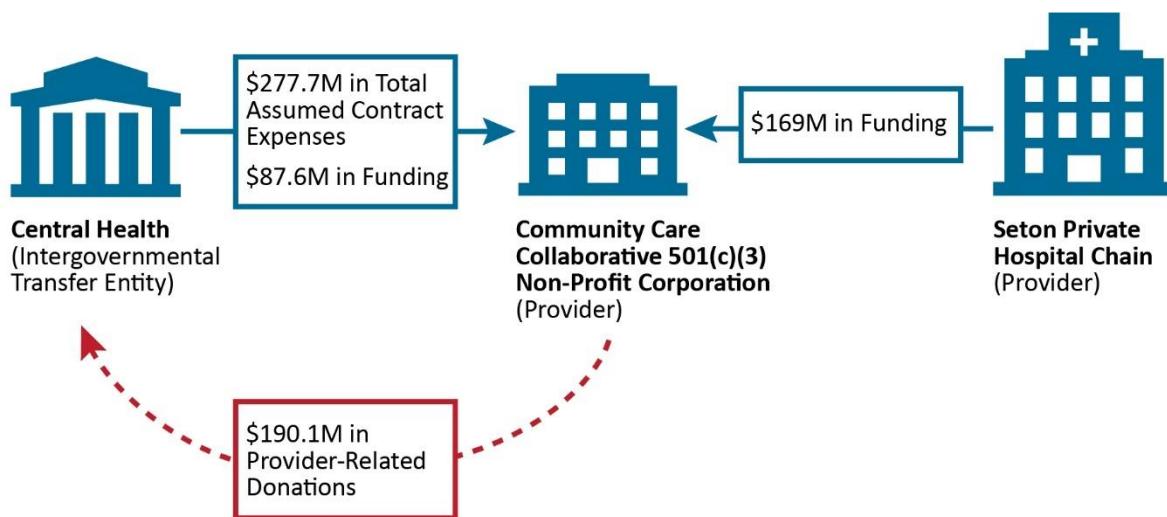
CCC and Seton made indirect provider-related donations that benefited Central Health. Prior to the creation of CCC, Central Health held contracts with providers to provide medical services to Travis County's uninsured and underinsured populations. CCC took over those contracts from Central Health. The contracts' scope of services and payment arrangements remained virtually the same under CCC.

⁸ The exact inappropriate Federal share is \$83,833,972.

⁹ 42 CFR § 433.52.

CCC's assumption of the contracts resulted in \$190.1 million in indirect provider-related donations. CCC paid \$277.7 million for services provided under the assumed contracts. Those expenditures exceeded Central Health's financial support by \$190.1 million (i.e., \$277.7 million less Central Health's financial support of \$87.6 million paid to CCC), which Seton and CCC completely funded. Thus, Central Health avoided incurring those expenditures itself. Although CCC paid the expenditures for services provided under the assumed contracts, Seton contributed to them through its \$169 million in financial support to CCC. Additionally, the \$190.1 million in Central Health's avoided expenditures is roughly the same amount that Central Health transferred for Seton's and CCC's DSRIP Program payments (i.e., \$189.3 million). Figure 1 shows how the impermissible provider-related donations were made.

Figure 1: How Community Care Collaborative and Seton Made Impermissible Provider-Related Donations to Central Health



Central Health would continue to incur the medical service expenses in the absence of CCC. If Central Health did not resume funding the programs under the contracts that CCC assumed, Travis County residents would lose access to vital services on which they have relied for over 30 years.¹⁰ Further, Central Health officials told us that if CCC ceased to exist, Central Health would need to reevaluate the coverage provided under the programs and that Central Health would be a major source of funding for the reevaluated programs.

The Funds Central Health Transferred Resulted From Provider-Related Donations

The funds Central Health transferred to the State agency to cover the State share of CCC's and Seton's DSRIP Program payments resulted from provider-related donations. Because CCC assumed Central Health's contracts and funded the related expenditures, Central Health avoided incurring those expenses and operating at an extreme loss. During the fiscal years Central Health transferred \$189.3 million to fund the State share of CCC's and Seton's DSRIP

¹⁰ The county medical service programs have existed in some form since at least the 1980s.

Program payments, its revenues were either less than its expenses or narrowly exceeded them. Central Health did not have the funds available to both pay the medical service expenditures that CCC assumed and to fund the State share of DSRIP Program payments made to CCC and Seton via IGTs. Central Health only had the funds to transfer the State share of CCC's and Seton's payments because CCC and Seton funded the contract expenditures that were previously Central Health's responsibility.

The Donations Were Part of a Hold-Harmless Practice

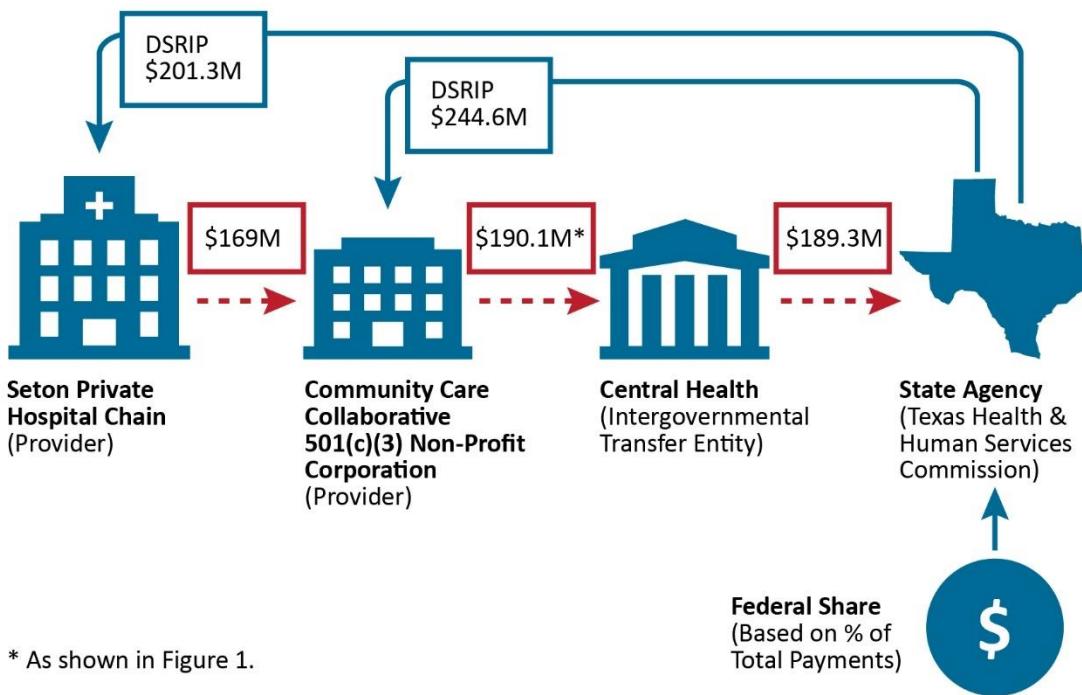
Permissible provider-related donations have no direct or indirect relationship to Medicaid payments to the provider, providers furnishing the same class of items and services as the provider, or any entity related to the provider. For donations to have no direct or indirect relationship to Medicaid payments, the donations must not be returned to the provider or a related entity under a "hold-harmless" provision or practice. Such a provision or practice exists if any of three tests applies, one of which is the guarantee test. The guarantee test is met if the State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver that directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation).¹¹

CCC's and Seton's donations to Central Health were part of a hold-harmless practice. The funding arrangement among Seton, CCC, and Central Health met the guarantee test because providers knew, or could reasonably expect, that they would receive back all or most of their donated funds, and in fact, received back these funds. Because of the structure of the DSRIP Program, Central Health (as the RHP 7 anchor) had the power to and did direct the majority of Region 7's DSRIP Program funds to CCC and Seton. Those two parties received almost 65 percent of the \$689.1 million in DSRIP funds the State agency allocated to all Region 7 providers.

CCC and Seton donated \$190.1 million to Central Health by assuming the contracts and paying for services provided under those contracts. In return, CCC and Seton received DSRIP Program payments of \$445.9 million (\$244.6 million in payments to CCC and \$201.3 million in payments to Seton). Figure 2 shows that CCC's and Seton's DSRIP Program payments resulted from their donations.

¹¹ 42 CFR § 433.54.

Figure 2: Illustration of Community Care Collaborative and Seton Receiving DSRIP Program Payments as a Result of Their Donations to Central Health



CONCLUSION AND RECOMMENDATIONS

Of the \$189.3 million in funds that the State agency used as the State share of DSRIP Program payments, Central Health transferred \$146.6 million after CMS issued its letter that offered guidance on the use of provider-related donations to finance Medicaid payments. The State agency did not decrease its Medicaid expenditures by the \$146.6 million as specified by Federal requirements. As a result, the State agency inappropriately received \$83.8 million in Federal funds. The following table identifies the impermissible provider-related donations by the FY in which the State agency claimed the related DSRIP Program payments, the applicable FMAP, and the inappropriate Federal share.

Table: Breakdown of the Impermissible Provider-Related Donations and the Inappropriate Federal Share

FY Claimed	Impermissible Donations	FMAP	Inappropriate Federal Share
2014	\$1,774,872	58.69%	\$1,041,672
2015	50,691,810	58.05%	29,426,596
2016	49,991,985	57.13%	28,560,421
2017	44,153,227	56.18%	24,805,283
Total	\$146,611,894		\$83,833,972

The impermissible provider-related donations ultimately relieved the State agency of its obligation to provide its mandated share of CCC's and Seton's DSRIP Program payments. Therefore, we recommend that the Texas Health and Human Services Commission:

- refund \$83,833,972 in Federal funds it inappropriately received because it used IGTs derived from impermissible provider-related donations to fund the State share of DSRIP Program payments;
- provide its IGT entities with guidance about arrangements that may result in impermissible provider-related donations, such as those outlined in CMS's clarifying letter; and
- request that its IGT entities disclose whether similar arrangements exist and provide the State agency with action plans on ending the arrangements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our third recommendation to the extent that it contemplates identifying arrangements that resemble those at issue in the counties named in DAB No. 2886 and provided information on actions it had taken related to that recommendation. The State agency did not concur with our first and second recommendations.

Regarding our first recommendation, the State agency said that we did not demonstrate that the arrangement described in our report involved impermissible provider-related donations under Federal law. The State agency said it was inappropriate for us to rely on determinations made in the SMDL and in DAB No. 2886 regarding provider-related donations. The State agency stated that we should not rely on the decision in DAB No. 2886 because the arrangement described in this report is not the same as the arrangement reviewed by the DAB. The State agency considers DAB No. 2886 unsettled because it continues to challenge that decision in Federal court. The State agency also contends that the SMDL is confusing and unclear and that it constitutes illegal legislative rulemaking because it is a new interpretation of regulation that CMS issued without notice and comment rulemaking.

Additionally, the State agency believes that we applied a test created in DAB No. 2886 that it refers to as the "reasonable expectation test" to establish the hold-harmless practice, and the State agency believes that such test should not apply. The State agency identified passages in our report describing the RHP anchor's role that the State agency sees as misleading or incorrect.

Finally, the State agency believes it was incorrect for us to apply DAB No. 2886 to payments in our audit period (i.e., DSRIP Program payments for December 12, 2011, through September 30, 2016) because it was not decided until August 7, 2018.

Regarding our second recommendation, the State agency stated that it had provided the SMDL to its RHP anchors on May 30, 2014. However, the State agency said that the state of the law is unclear, and providing guidance to IGT entities would constitute provision of legal advice, which the State agency does not have the authority to do.

The State agency's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our finding and recommendations are valid.

Regarding our first recommendation, Federal regulations provide that the guarantee test of the hold-harmless provision is met if the State receiving the donation guarantees to return any portion of the donation to the provider. As described in the report, providers were guaranteed to receive back all or most of their donated funds. The State's contention that the "reasonable expectation test" should not apply does not negate that our finding regarding impermissible provider-related donations is based on Federal regulation and therefore remains valid.

While the arrangement described in this report is not exactly the same as the arrangement reviewed in DAB No. 2886, both arrangements involve impermissible provider-related donations in which a provider entity assumed an expense that the government entity would otherwise incur, thus making funds available for IGT. In addition, DAB's decision represents the final administrative decision of the Department and is applicable to the Medicaid program.

In regard to the State agency's position that the SMDL is confusing and unclear, we would point out that the provision to which the State agency refers (i.e., the SMDL's description of a public-private partnership arrangement) clearly includes the arrangement at issue in this report. Specifically, the SMDL states that public-private partnership arrangements include in-kind transfers of value and that arrangements in which IGTs derived from funds that the government entity only has available because services are now being provided by the private entity are not bona fide. We do not opine on the State agency's contention that the SMDL constitutes illegal legislative rulemaking, as such question is outside the scope of this audit.

Also, based on the results of RHP 7's funding allocations and communications between Central Health and interested providers, we maintain that we have accurately reflected Central Health's role as the anchor for RHP 7.

Finally, while we acknowledge that DAB No. 2886 was not decided until after our audit period, we reiterate that the arrangement described in the audit report constitutes a hold-harmless provision in violation of Federal regulations that applied during our audit period, and DAB No. 2886 affirms such application of Federal law and regulations regarding provider-related donations.

Regarding our second recommendation, simply providing the SMDL was not enough to adequately prevent the arrangement identified in our report, as evidenced by our questioned payments that occurred after issuance of the SMDL. In addition, our recommendation was to provide IGT entities with guidance, not just RHPs in the DSRIP Program. Our intention was to include IGT entities providing the State share for Medicaid payments in general, not just those providing the State share of DSRIP Program payments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$189.3 million in funds used as the State share of \$445.9 million (\$244.6 million in payments to CCC and \$201.3 million in payments to Seton) in DSRIP Program payments made to CCC and Seton for December 12, 2011, through September 30, 2016 (demonstration years 1 through 5), which the State agency paid and claimed during Federal FYs 2013 through 2017.

We limited our review of the State agency's internal controls to those related to the DSRIP Program because our objective did not require an understanding of the State agency's overall internal control structure.

We conducted our fieldwork at the State agency and CCC offices in Austin, Texas.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, requirements, and guidance governing the source of State share of Medicaid expenditures;
- reviewed the State agency's approved waiver;
- interviewed State agency officials to gain an understanding of the State agency's policies and procedures related to DSRIP Program payments and reviewed the State agency's written policies and procedures;
- identified all providers that received DSRIP Program payments for demonstration years 1 through 5 by tracing DSRIP Program expenditures the State agency claimed on the CMS-64 reports to detailed supporting payment data;
- selected CCC's and the two Seton hospitals' DSRIP Program payments for validation of the related State share funds' source;
- interviewed Central Health and CCC officials to gain an understanding of Central Health's and CCC's policies and procedures related to obtaining and transferring the State share of DSRIP Program payments and reviewed their written policies and procedures;
- reviewed minutes of meetings during which the creation and intent of CCC was discussed;

- traced the flow of funds among the State agency, Central Health, CCC, and Seton by tracing the State share of DSRIP Program payments to Central Health's banking transfer records, reviewing CCC's and Central Health's financial statements, and analyzing deposit transactions in CCC's bank accounts;
- compared (1) the payment terms and scopes of services in the last contracts that Central Health held with select health care providers and an administrative services contractor to (2) the payment terms and scopes of services in new contracts that CCC assumed;¹²
- calculated the Federal share the State agency received as a result of impermissible donations by multiplying the State share of CCC's and Seton's payments by the FMAP in effect when the DSRIP Program payments were claimed; and
- discussed the results of our audit with State agency, Central Health, and CCC officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹² The selected health care providers and the administrative services contractor accounted for more than 77 percent of CCC's health care delivery costs.

APPENDIX B: STATE AGENCY COMMENTS



Texas Health and Human Services Commission

Phil Wilson

Executive Commissioner

May 18, 2020

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Re: Number A-06-17-09002

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled *Texas Relied on Impermissible Provider-Related Donations to Fund the State Share of the Medicaid Delivery System Reform Incentive Payments Program* from the U.S. Department of Health and Human Services Office of Inspector General.

The cover letter, dated February 19, 2020, requested that HHSC provide written comments, including a statement of concurrence or nonconcurrence with each recommendation and the reasons for our non-concurrence or the status of actions taken or planned in response to report recommendations for which we concur.

I appreciate the opportunity to respond. Please find the attached HHSC management response which includes (a) comments related to the content of the findings and recommendations, (b) our reasons for any non-concurrence, and/or (c) details actions HHSC has completed or planned.

Should you have any questions, Jose Garcia, Office of Audit and Compliance Interim Deputy Director, serves as lead on this matter and can be reached by phone at 512-927-7454 or by email at jose.garcia@hhsc.state.tx.us.

Sincerely,

Phil Wilson

Office of Inspector General Note --The deleted text has been redacted from this Appendix because it contains personally identifiable information.

P.O. Box 13247 • Austin, Texas 78711-3247 • 512-424-6500 • hhs.texas.gov

Texas Health and Human Services Commission (HHSC)
Management Response to the
U.S. Department of Health and Human Services Office of Inspector General
Draft Report dated February 19, 2020 - A-06-17-09002
"Texas Relied on Impermissible Provider-Related Donations To Fund the State Share of the Medicaid Delivery System Reform Incentive Payments Program (DSRIP)"

INTRODUCTION

A. DSRIP Audit

On March 3, 2017, the U.S. Department of Health and Human Services Office of Inspector General (DHHS-OIG) notified the Texas Health and Human Services Commission (Texas HHSC) of its intent to conduct an audit of the Delivery System Reform Incentive Payment (DSRIP) program. The audit period was December 12, 2011 (when the DSRIP program began) through September 30, 2016.

For its audit, the DHHS-OIG selected Regional Healthcare Partnership (RHP) 7 and RHP 9 for review. For RHP 7, the auditors focused on the Travis County Hospital District, doing business as Central Health (Central Health), and on the Community Care Collaborative (CCC) and Seton Healthcare Family (Seton). For RHP 9, the auditors focused on the Dallas County Hospital District, doing business as Parkland Health and Hospital System. The DHHS-OIG conducted fieldwork at Texas HHSC and in RHPs 7 and 9.

At this time, Texas HHSC has received one draft report from the audit. On February 19, 2020, the DHHS-OIG issued its draft report titled *Texas Relied on Impermissible Provider-Related Donations To Fund the State Share of the Medicaid Delivery System Reform Incentive Payments Program*. According to the draft report, the objective of the DHHS-OIG's audit was "to determine whether the Texas HHSC (State agency) used permissible funds as the State share of DSRIP Program payments."¹

B. History of Federal Actions

There is a long history of arbitrary federal actions underlying the claims in the DHHS-OIG's report, including improper legislative

¹ At the outset of the audit, the stated objective was "to determine whether DSRIP expenditures were calculated and claimed in accordance with Federal and State regulations." Letter of engagement from [REDACTED] Audit Manager, DHHS OIG, to [REDACTED] Executive Commissioner, Texas HHSC, p. 1 (undated). The DHHS-OIG did not provide an explanation prior to the issuance of the draft report for the discrepancy between the stated objective at the outset of the audit and the stated objective in the draft audit report.

rulemaking and unclear guidance. The following summarizes this history:

1. 2008 Health Care-Related Taxes Rule
 - CMS revised 42 C.F.R. § 433.68(f), which addresses hold harmless arrangements in the context of health care-related taxes, and also revised 42 C.F.R. § 433.54(c), which addresses hold harmless arrangements in the context of bona fide donations.²
 - In the preamble summary of changes to § 433.68(f)(3), CMS explained that “[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the *reasonable expectation* that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments).”³
 - The “reasonable expectation” standard described in the preamble was not made a part of the actual hold harmless provisions in § 433.68(f)(3) or § 433.54(c)(3).
 - CMS’s summary of the “reasonable expectation” standard was solely in the context of health care-related taxes; CMS did not specify that the standard would apply to provider-related donations.
2. 2014 State Medicaid Director Letter (SMDL) #14-004
 - CMS released SMDL #14-004, which purported to “help clarify for states what is authorized under the law”⁴ but actually promoted a new policy that was inconsistent with the law.
 - The SMDL described when a hold harmless arrangement exists, but the “reasonable expectation” standard, first described in the 2008 health care-related taxes rule preamble, was not part of the analysis.
3. 2014 & 2015 CMS Deferral
 - Following a financial management review of uncompensated care (UC) payments to private hospitals in three areas of the state, including Dallas and Tarrant Counties, CMS deferred in 2014,

² Medicaid Program; Health Care-Related Taxes, 73 Fed. Reg. 9685-01 (February 22, 2008).

³ 73 Fed. Reg. at 9694 (emphasis added).

⁴ SMDL at 5 (May 9, 2014).

then released in 2015, the deferral of \$74 million in federal financial participation (FFP).⁵

- The deferral was related to the source of the non-federal share of the payments and private hospital funding arrangements.
- During 2015, CMS and HHSC engaged in extensive discussions, with HHSC providing substantial documentation and information, about the private hospital funding arrangements.
- In the summer of 2015, CMS proposed identifying a “test case” to get the issue before an independent arbiter.⁶

4. 2016 CMS Disallowance TX/2016/001/MAP

- CMS notified Texas HHSC of the disallowance of \$26,844,551 in FFP for UC payments to private hospitals in Dallas and Tarrant counties for the fourth quarter of federal fiscal year 2015.⁷
- CMS alleged that the private hospitals’ provision of charity care to patients who previously received such care, or a portion thereof, from a governmental entity constituted an impermissible provider-related donation.
- This set the stage for the “longstanding dispute”⁸ between CMS and the State regarding the propriety of the local funding mechanism to be decided as a “test case” by the Departmental Appeals Board (DAB).
- HHSC appealed the final disallowance decision of CMS to the DAB on February 24, 2017.

5. 2018 & 2019 DAB Rulings and Subsequent Appeal

- The DAB issued Decision No. 2886, affirming the disallowance but reducing the amount thereof.⁹
- The DAB concluded that the private hospitals were held harmless because they had a reasonable expectation that they would receive an offsetting government payment.¹⁰
- The DAB also concluded that it didn’t need to apply the “reasonable expectations” standard because the “net effect” of

⁵ Letter from [REDACTED] to [REDACTED] Director, HHSC (Sept. 30, 2014); Letter from [REDACTED] to [REDACTED] Director, HHSC (Jan. 7, 2015).

⁶ Email from [REDACTED] HHSC, to [REDACTED] CMS (Sept. 12, 2016).

⁷ Letter notifying HHSC of Disallowance TX/2016/001/MAP (Sept. 1, 2016).

⁸ CMS’s Brief in Support of Disallowance at 1 (Aug. 25, 2017).

⁹ DAB No. 2886, Texas Health and Human Services Commission at 36 (Aug. 7, 2018).

¹⁰ See *id.* at 25.

- the arrangements amounted to impermissible provider donations.¹¹
- Texas HHSC and certain private hospitals acting as intervenors filed a joint motion for reconsideration and reversal, which the DAB denied on October 2, 2019.
 - On December 2, 2019, in the United States District Court for the Northern District of Texas, Dallas Division, Texas HHSC filed a complaint seeking judicial review of DAB Decision No. 2886.¹²
 - In its request for relief, Texas HHSC asked the federal district court to set aside and reverse the DAB’s decision and to declare that the SMDL constituted illegal legislative rulemaking.
6. 2019 Medicaid Fiscal Accountability Regulation
- CMS published a new proposed rule addressing provider-related donations and purporting to codify the “reasonable expectation” and the “net effect” tests.¹³
 - The proposal would amend 42 C.F.R. § 433.52 to add a definition of “net effect” that includes the “reasonable expectations of the participating entities.”¹⁴
 - The proposal would also amend 42 C.F.R. § 433.54(c)(3) to specify that a direct guarantee will be found when “the net effect of an arrangement...results in a reasonable expectation that the provider, provider class, or related entities will receive a return of all or a portion of the donation either directly or indirectly.”¹⁵

CMS’s regulatory activities regarding the non-federal share have been results-oriented and disregard substantive law and procedural requirements. If CMS wishes to impose the reasonable expectation and net effects tests, it must comply with the Administrative Procedure Act to ensure states are given proper notice and the opportunity to comment.¹⁶ As it is, CMS has failed to clearly and lawfully

¹¹ *Id.*

¹² *Texas Health and Human Services Commission v. United State Department of Health and Human Services*, Case 3:19-cv-02857.

¹³ Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63722 (Nov. 18, 2019).

¹⁴ *Id.* at 63738.

¹⁵ *Id.* at 63739.

¹⁶ This Administration has been very clear that “it is the policy of the executive branch, to the extent consistent with applicable law, to require that agencies treat guidance documents

communicate its expectations to the state. For these reasons, the final audit report should address the regulatory shortcomings of CMS rather than penalize the state for relying on CMS's regulations and conduct over the course of a decade.

C. Unsettled Law

The state of the law upon which the audit report relies is unresolved, and as such, the recommendations in the report should be withdrawn. The chart below shows the status of the legal issues underlying DHHS-OIG's recommendations. These issues are unresolved, and the matters described in the report are not ready for DHHS-OIG's review.

Underlying legal issues	Status
DAB decision	Unresolved <ul style="list-style-type: none">• Decision No. 2886 issued August 7, 2018• Ruling on Request for Reconsideration issued October 2, 2019• Undergoing federal judicial review
SMDL	Unresolved <ul style="list-style-type: none">• Challenged in Decision No. 2886 judicial review
MFAR	Unresolved <ul style="list-style-type: none">• Proposed November 18, 2019• Not final

The sources relied upon in the report do not constitute settled law. Rather, they reflect matters that are still being debated. As such, reliance on them is not proper.

Per DHHS-OIG's request that Texas HHSC provide written comments regarding the draft audit report, including a statement of concurrence or nonconcurrence with each recommendation, Texas HHSC provides the following:

as non-binding...." Exec. Order No. 13,891 (Oct. 9, 2019). While agencies may clarify existing obligations through non-binding guidance documents, legally-binding requirements may be imposed on the public "only through regulations and on parties on a case-by-case basis through adjudications, and only after appropriate process." *Id.*

RESPONSE TO RECOMMENDATION 1

Recommendation 1: The State agency refund \$83,833,972 in Federal funds it inappropriately received because it used IGTs derived from impermissible provider-related donations to fund the State share of DSRIP Program payments.

Response: Texas HHSC does not concur with this recommendation for the reasons set out below.

I. DHHS-OIG has not demonstrated that the arrangement described in the audit report involves impermissible provider-related donations.

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.¹⁷

Under federal law, provider-related donations can be included as the non-federal share of Medicaid expenditures as long as they are “bona fide” donations.¹⁸ A “bona fide provider-related donation” is defined as a provider-related donation that has no direct or indirect relationship to payments made under title XIX to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity.¹⁹ Provider-related donations are determined to have no direct or indirect relationship to Medicaid payments if the donations are not returned to the individual provider, provider class, or related entity under a hold harmless provision or practice.²⁰

Under § 433.54(c), a hold harmless practice exists if any of the following applies:

- (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

¹⁷ 42 U.S.C. § 1396b(w)(2)(A) (2014); 42 C.F.R. § 433.52 (2014).

¹⁸ 42 U.S.C. § 1396b(w)(1)(A)(i); 42 C.F.R. § 433.54.

¹⁹ 42 U.S.C. § 1396b(w)(2)(B).

²⁰ 42 C.F.R. § 433.54(b).

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.

(3) The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver such that the 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).

The draft audit report concludes that the arrangement described in the report constitutes a hold harmless practice, but it fails to apply the law to demonstrate that this is so. Texas HHSC cannot concur with this recommendation in the absence of a robust and convincing legal analysis.

II. The DHHS-OIG's reliance on the State Medicaid Director Letter is improper.

The draft report relies on State Medicaid Director Letter (SMDL) #14-004 to support its recommendations and to justify the initial date from which it calculated the amount it recommends that Texas HHSC return. However, reliance on the SMDL is faulty for several reasons.

First, the SMDL constitutes illegal legislative rulemaking because it is inconsistent with 42 C.F.R. § 433.54(c). When a federal agency "supplements a statute, adopts a new position inconsistent with existing regulations, or otherwise effects a substantive change in existing law or policy," that action constitutes legislative rulemaking, and the agency must promulgate the rule through the notice and comment rulemaking process described in the Administrative Procedure Act.²¹ CMS supplemented a statute and adopted a new position inconsistent with the existing regulation when it stated that a donation "would not be considered bona fide when such arrangements are tied *in any way*, directly or indirectly, to Medicaid

²¹ See *Children's Hospital of the King's Daughters, Inc. v. Azar*, 896 F.3d 615, 620 (4th Cir. 2018).

reimbursement under the Medicaid state plan.²² This was not a reasonable interpretation of § 433.54(c).

Second, even if the SMDL was not illegal legislative rulemaking, DHHS-OIG should not rely on it because it is confusing and unclear.²³ For example, the SMDL says, "A public-private partnership arrangement is a relationship between a private entity and a government entity in which the private entity agrees, in some form, to provide a service or *some other in-kind transfer of value* to further the purposes of the government entity."²⁴ CMS itself seemed to have trouble articulating what was prohibited, so it should come as no surprise that the states relying on CMS's guidance had difficulty implementing it. If CMS intends to impose a condition on the grant of federal moneys, it must do so unambiguously.²⁵

Third, it is improper to rely on the SMDL because the letter does not impose the test upon which the report's conclusion rests. The DHHS-OIG report applies the reasonable expectation test, a test that was articulated in Departmental Appeals Board (DAB) Decision No. 2886.²⁶ However, this test does not appear in the SMDL. Accordingly, it is not appropriate to use the SMDL as the trigger for calculating repayment amounts for ostensible violations of the reasonable expectation test.

Finally, as noted above, Texas HHSC's suit for judicial review challenges the SMDL as illegal legislative rulemaking. As such, reliance on the SMDL is

²² SMDL at 4 (emphasis in the original).

²³ The SMDL's lack of clarity matters because it goes to the persuasiveness of the letter and the level of deference a court would give it. When a court reviews interpretive guidance that is not the product of formal, notice-and-comment rulemaking, "[it] is entitled to respect 'to the extent that the interpretations have the power to persuade.'" *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401, 409 (6th Cir. 2007) (quoting *Bank of New York v. Janowick*, 470 F.3d 264, 269 (6th Cir. 2006)). Factors that give an interpretation power to persuade include the thoroughness evident in the agency's consideration, the validity of its reasoning, and its consistency with earlier and later pronouncements. *Estate of Landers v. Leavitt*, 545 F.3d 98, 107 (2d Cir. 2008), as revised (Jan. 15, 2009) (citing *U.S. v. Mead*, 533 U.S. 218, 228 (2001)).

²⁴ SMDL #14-004 at 3 (May 9, 2014) (emphasis added).

²⁵ *Hawaii Department of Human Services et al, Ruling on Request for Reconsideration*, DAB 1981, issued Feb. 22, 2006 (citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17 (1981)).

²⁶ "The funding arrangement among Seton, CCC, and Central Health met the guarantee test because providers knew, *or could reasonably expect*, that they would receive back all or most of their donated funds...." Draft audit report at 7 (emphasis added).

faulty because its status as legally-promulgated agency guidance is in question.

In short, the draft audit report improperly relies on the SMDL both for the finding of impermissible provider-related donations as well as the initial date from which it calculates the amount of the requested refund.

III. The DHHS-OIG's reliance on Departmental Appeals Board Decision No. 2886 is misplaced.

The DHHS-OIG audit report relies on DAB Decision No. 2886 to support Recommendation 1. Reliance on that decision is misplaced for several reasons.

First, Decision No. 2886 was wrongly decided in that it contained incorrect recitations of both fact and law, including the creation of a new test to justify its decision. Even though CMS and the DAB considered Disallowance Number TX/2016/001/MAP a "test case", that did not mean the DAB was free to create a new legal test to decide if the arrangements at issue involved impermissible provider-related donations.

Second, DHHS-OIG should not rely on the DAB decision because the arrangement described in the audit report is not the same as the arrangement reviewed by the DAB. Even if DAB Decision No. 2886 had been correctly decided, the facts upon which this report is based are not sufficiently similar to the facts in the DAB decision for the DAB decision to be decisive.

Third, reliance by DHHS-OIG on Decision No. 2886 is premature as Texas has filed a petition for judicial review, and that appeal is pending.²⁷ DHHS-OIG should refrain from citing as precedent a DAB decision that is not yet settled law.

Finally, even if reliance on Decision No. 2886 is not premature, the decision was not released until almost two years after the end of the audit period, as set out in the timeline below:

²⁷ *Texas Health and Human Services Commission v. United State Department of Health and Human Services*, Case 3:19-cv-02857.

Dec. 12, 2011	Start of the DSRIP program/ Start of the audit period
Sept. 30, 2016	End of the audit period
Aug. 7, 2018	DAB issues Decision No. 2886 affirming disallowance

Even at the end of the audit period, Texas HHSC could not have complied with the holding set forth in Decision No. 2886, because it would be nearly two years until the decision would be issued.

IV. Under the law as it existed during the period the DHHS-OIG auditors examined, there are no grounds for DHHS-OIG to recommend return of the federal share.

The DHHS-OIG's report relies on DAB Decision No. 2886 and adopts the reasonable expectation test described in that decision. The reasonable expectation test, however, is inconsistent with current statute and regulation. This inconsistency is evident in CMS's own recent rulemaking action, which purports to codify the reasonable expectation and net effect tests.²⁸ The draft report attempts to improperly apply the reasonable expectation test, even though CMS has not yet incorporated the test into regulation.

CMS's proposed Medicaid Fiscal Accountability Regulation (MFAR) makes it clear that the law, as it existed during the period the DHHS-OIG auditors examined, did not include the reasonable expectation test, nor did it prohibit the kind of arrangement identified in the audit. Therefore, there is no legal basis for DHHS-OIG to recommend return of the funds, and DHHS-OIG should remove this recommendation in the final report.

V. The report contains other factual inaccuracies.

The report contains several factual inaccuracies regarding operation of DSRIP in Texas that should be corrected because the inaccuracies affect DHHS-OIG's analysis and recommendations. First, the report states:

The waiver established 20 regional healthcare partnerships (RHPs) throughout Texas. Under these RHPs, providers are grouped together within the same geographic boundary. Each RHP is

²⁸ Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722 (Nov. 18, 2019).

anchored by a public hospital or local government entity, which *financially supports the DSRIP Program within its geographic boundaries and has the authority to make IGTs.*²⁹

A more accurate way to describe the anchors' role would be to say: "Each RHP is anchored by a public hospital or local government entity, which administratively supports the DSRIP Program within its geographic boundaries and has the authority to make IGTs."³⁰

Next, the report contains a paragraph that begins:

The Travis County Healthcare District, doing business as Central Health, anchors the Region 7 RHP, which encompasses Bastrop, Caldwell, Fayette, Hays, Lee, and Travis Counties. *As the RHP 7 anchor entity, Central Health controlled the level of DSRIP Program payments that an RHP 7 provider could receive.*³¹

The second, italicized sentence is very misleading, as the anchor doesn't control full allocation, and should be removed. There were multiple requirements for DSRIP allocations among providers within a region. As the RHP 7 anchor entity, Central Health guided the process and worked with stakeholders to meet the requirements, but final valuations were reviewed and approved by CMS.

Similarly, Texas HHSC requests that DHHS-OIG remove the stricken portion of the following sentence on page 7 of the report:

Because of the structure of the DSRIP Program, Central Health (as the RHP 7 anchor) ~~had the power to and did direct the majority of Region 7's DSRIP Program funds to CCC and Seton~~ guided the progress and worked with stakeholders to meet requirements for projects and valuations. Final valuations were approved, based on RHP Plan requirements, by CMS.

²⁹ Draft audit report at 2 (emphasis added).

³⁰ See Texas Healthcare Transformation and Quality Improvement 1115 Waiver, Texas DSRIP Program Funding and Mechanics Protocol, paragraph 1 (August 30, 2012).

³¹ Draft audit report at 2 (emphasis added).

The draft report misrepresents the role of the anchor and disregards the oversight that CMS provided. Correction of these factual errors is important because they wrongly imply that a hold harmless practice existed. Under 42 C.F.R. § 433.54, provider-related donations have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provisions or practice. The regulation further provides that a hold harmless practice exists if the state or other unit of government receiving the donation provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider.³² By incorrectly stating that Central Health possessed powers that it did not have, the report suggests a hold harmless practice existed, a suggestion that Texas HHSC contests.

Finally, page 5 incorrectly states that Texas HHSC did not provide its IGT entities with guidance about the arrangements in the SMDL. As discussed in a meeting with the federal auditors on May 6, 2019, HHSC provided the SMDL to the RHP anchors just after the SMDL was released. The report should be corrected to reflect this fact.

RESPONSE TO RECOMMENDATION 2

Recommendation 2: The State agency provide its IGT entities with guidance about arrangements that may result in impermissible provider-related donations, such as those outlined in CMS's clarifying letter.

Response: Texas HHSC does not concur with this recommendation. DHHS-OIG recommends that Texas HHSC "provide its IGT entities with guidance about arrangements that may result in impermissible provider-related donations to fund the State share of DSRIP Program payments." This recommendation disregards that the DSRIP program did provide the SMDL to its RHP anchors on May 30, 2014. It further disregards that Texas HHSC has been in discussions with CMS about the law surrounding provider-related donations since 2007 and is currently in active litigation with CMS about the very issue the DHHS-OIG report purports to address.³³

³² 42 C.F.R. § 433.54(c)(3).

³³ CMS and Texas HHSC worked closely in 2007 and 2008 on issues surrounding public-private partnerships and the non-federal share.

The state of the law on provider-related donations is unsettled because CMS has failed to provide clear guidance promulgated in a way that complies with the Administrative Procedure Act. Any effort by Texas HHSC to “provide IGT entities with guidance,” as DHHS-OIG suggests, would further confuse the situation because CMS’s positions have been shifting for over a decade. The state of the law on provider-related donations is so unclear that guidance to IGT entities would constitute the provision of legal advice, something Texas HHSC does not have the authority to do.

RESPONSE TO RECOMMENDATION 3

Recommendation 3: The State agency request that its IGT entities disclose whether similar arrangements exist and provide the State agency with action plans on ending the arrangements.

Response: Texas HHSC concurs with this recommendation to the extent that it contemplates identifying arrangements that resemble those at issue in Dallas and Tarrant, and in that regard, Texas HHSC has already taken the recommended action.

Actions Completed or Planned: In December 2018, Texas HHSC conducted the first ever large-scale survey of the sources of the non-federal share of Medicaid payments in Texas. For a private hospital to participate in the UC or DSRIP program, Texas HHSC must have an affiliation agreement and certifications of participation from that entity and its affiliated local public entity. Texas HHSC required all members of an affiliation on record to submit a description of the nature of the local funding structure between the two parties.

Texas HHSC received and reviewed the affiliates’ descriptions of the nature of their local funding structures. For the structures that appeared to be similar to those at issue in Dallas and Tarrant counties, Texas HHSC informed the affiliates that CMS may view their funding structure as an impermissible provider-related donation. Texas HHSC further informed those affiliates that the legal issues surrounding those structures were being reviewed by neutral arbiters.

Target Implementation Date: All planned action completed by December 31, 2018

CONCLUSION

Texas HHSC does not concur with Recommendations 1 or 2 because these recommendations disregard years of conflicting guidance from CMS and the fact that Texas HHSC was during the audit period and is still now in an active dispute with CMS regarding its interpretation of the law concerning provider-related donations. Further, the recommendations rely on CMS's legislative rulemaking, which was issued without following the proper notice and comment process and upon which reliance is clearly prohibited by executive order. Finally, the recommendations are contradicted by CMS's own recently issued MFAR. Texas HHSC concurs with Recommendation 3 to the extent that it contemplates identifying arrangements that resemble those at issue in Dallas and Tarrant Counties and has completed that recommendation.