UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

THE STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION, Plaintiffs, v. CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services, *et al.*, Defendants.	§ § § § § § § § § § § §	Case No. 6:21-cv-00191-JCB

PLAINTIFFS' NOTICE REGARDING REQUEST FOR ORAL HEARING

Plaintiffs the State of Texas and Texas Health and Human Services Commission hereby notify the Court of their withdrawal of their request for an oral hearing on their pending Motion to Enforce the Preliminary Injunction. ECF 75 at 2, 29.

When Plaintiffs filed the motion on November 11, 2021, they requested an oral hearing because of the importance to Medicaid providers of obtaining CMS's compliance with the preliminary injunction and because of the number of issues raised in the motion. The need for resolution of the issue that remains unresolved—whether CMS has the authority to regulate private agreements between healthcare providers—is even more urgent today. *See* ECF 84 at 1. As indicated in the letter from Texas Medicaid providers attached as Exhibit A, CMS's failure to approve Texas's state directed-payment programs is having a devastating impact on healthcare providers who, without Texas's Medicaid supplemental payments, "cannot sustainably provide the care that [Texas's] medically underserved communities currently receive." Ex. A at 1. Moreover, Texas is now experiencing a surge in hospitalizations as a result of the spread of the Omicron

variant, which is further impacting these providers.[1] The lack of approved state directed-payment programs in combination with the recent COVID-19 surges has increased the risk of imminent provider closures. *See generally* Ex. B. (Grady Declaration).

In light of this urgency, Plaintiffs withdraw their request for an oral hearing so that there is no need for the Court to delay its decision on the pending motion in order to accommodate Plaintiffs' request. Plaintiffs, however, remain willing to participate in an oral hearing if the Court would find it helpful.

[1] *See, e.g.*, Steven Dial, *Omicron variant surge to peak in late January in North Texas, UT Southwestern says*, FOX 4 (Jan. 3, 2022 8:33 PM), https://www.fox4news.com/news/omicron-variant-surge-to-peak-in-mid-january-in-north-texas-ut-southwestern-says; Karen Brooks Harper, *COVID-19 hospitalizations double in Texas as omicron strains staffing*, TEXAS TRIBUNE (Jan. 3, 2022), https://www.texastribune.org/2022/01/03/texas-covid-19-omicron/; Michelle Homer, *Texas Children's reports COVID cases more than double in one week with 12 babies in ICU*, KHOU (Jan. 4, 2022 4:45 AM), https://www.khou.com/article/news/health/coronavirus/texas-childrens-covid-cases-double-babies-icu/285-8f06a236-cc0f-40a4-aaab-4bb5b535f6f9; Megan Menchaca, *University of Texas reports record-high COVID-19 case count amid omicron surge*, AUSTIN AMERICAN-STATESMAN (Jan. 4, 2022 11:53 AM), https://www.statesman.com/story/news/2022/01/04/university-texas-covid-19-dashboard-omicron-variant-symptoms-surge/9089366002/.

Dated January 6, 2022

Respectfully submitted.

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CERTIFICATE OF SERVICE

I certify that on January 6, 2022, this brief was filed with the Court's CM/ECF system, which automatically serves a copy on all counsel of record.

/s/ Jeffrey M. White

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EXHIBIT A

December 17, 2021

The Honorable Joseph Biden
President of the United States of America
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

The Honorable Susan Rice
Assistant to the President for Domestic Policy and Director
Domestic Policy Council
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear President Biden, Director Rice, & Secretary Becerra:

On behalf of the hospitals, health systems, and health care providers we collectively represent, our associations urge the Biden Administration to direct the Centers for Medicare & Medicaid Services (CMS) to restore desperately needed funds to the Texas Medicaid program.

Over 5 million Texans are enrolled in Medicaid. Through innovative care models, the Texas Medicaid program serves this population and supports care for uninsured individuals. These groups include Texas's most vulnerable residents: its children, elderly, disabled, and indigent. Absent your intervention to restore Texas's receipt of supplemental payments, hospitals and their affiliated health care systems cannot sustainably provide the care that our medically underserved communities currently receive. Access to quality care will suffer. Indeed, for many providers, these payment programs represent the difference between operation and closure.

During the COVID-19 pandemic, Texas's Medicaid population grew significantly. Texas health care providers faced unprecedented demands, challenges, and constraints. Medicaid supplemental payment programs provided a lifeline, contributing approximately $9 billion to

sustain Texas's hospitals as they strove to meet the pressing needs of all Texans, especially those who face racial and ethnic health disparities.

Medicaid supplemental programs proved critical in the state's urban centers and along the border—areas where poverty rates are among the highest in the state. In Harris County, Medicaid supplemental payment programs provided over $2.6 billion. In Dallas County, Medicaid hospitals received over $1.4 billion. Along the border, in the Hidalgo Service Delivery Area—which includes the block of counties from Maverick south to Cameron—between 21% and 39% of the population depends on Medicaid. Supplemental payment programs contributed approximately $400 million to keep local providers solvent. Such funding enabled the high concentrations of Medicaid recipients in these areas to access lifesaving care.

Supplemental payment programs also helped sustain the state's 159 rural hospitals serving 3.1 million Texans, a disproportionate number of whom live in poverty. In a state that saw 27 rural hospitals in 22 communities close between January 2010 and February 2020—more than any other state in the nation during the same period—these funds kept providers' doors open.

In Texas, Local Provider Participation Funds (LPPFs)—local provider taxes approved and extended through state legislation and authorized under federal law—allow private providers to join public providers in being able to finance the nonfederal share and access critical federal matching dollars to help all Texas hospitals cover the costs of providing Medicaid and uninsured care.

LPPFs provide critical access to Medicaid financing to support critical services for uninsured and Medicaid-eligible Texans. In some areas of Texas, communities cannot sustain a governmental health care institution, and LPPFs are critical to sustain the local safety net. Even in areas that do have public hospitals and hospital districts, LPPFs enable private providers to more effectively provide care alongside the public system. Together, Texas' dedicated network of non-public and public providers rely heavily on LPPFs and the health care they make possible.

Although CMS has consistently approved Texas Medicaid supplemental payments funded by LPPFs since 2013, CMS has yet to approve this critical Medicaid funding to Texas because it argues that the LPPF contributors having private agreements, not involving government, prevents the federal government from providing matching dollars. CMS's objection is not only inconsistent with law and precedent, but it also represents an existential threat to all hospitals serving Texas's most at-risk populations, particularly as CMS seems to require an immediate cessation of LPPF funding. This situation leaves Texas's health system suddenly and severely underfunded.

Until now, CMS has never objected to similar private agreements anywhere in the nation. The U.S. Department of Health and Human Services (HHS) Office of the Inspector General issued a public report in 2003 concluding that wholly private arrangements between hospitals fell outside agency authority. More recently, CMS approved directed payment programs in Michigan and Tennessee even after these states signed onto a letter to CMS acknowledging awareness of private agreements. Regulated entities and stakeholders deserve consistent, predictable, and fair interpretation of applicable law.

CMS's current position resurrects an unsuccessful policy position included in the Medicaid Fiscal Accountability Regulation (MFAR), a rule the Trump Administration proposed and subsequently withdrew after a huge outcry from stakeholders and members of Congress on both sides of the aisle. CMS received over 10,000 comments in response to MFAR, many of which highlighted the devastating impact of the proposal and/or alleged that CMS lacked the statutory authority to justify its regulation of private agreements involving no state action. Although the administration oversaw the finalization of MFAR's withdrawal, CMS is now recycling this component of the abandoned proposal. Such action is concerning given that CMS gave no notice and engaged in no dialogue with states or providers regarding the revival of the unadopted and withdrawn rule.

At this critical juncture, we call upon the administration to remain consistent in its disavowal of MFAR's destructive policy. Each day that CMS cites this objection to withhold funding, Texas's hospitals face the growing risk that they will be unable to sustainably provide care.

Our members are extremely grateful for the administration's support throughout the pandemic, and we look forward to partnering with the White House and HHS to improve access to health care for all Americans. We ask that you ensure CMS restores the funding Texas hospitals desperately need at this time for the communities we serve.

Sincerely,

Stacy Wilson
President
Children's Hospital Association of Texas

Maureen Milligan
President/CEO
Teaching Hospitals of Texas

Larry L. Tonn
Principal
Texas Association of Voluntary Hospitals

Donald Lee
President
Texas Essential Healthcare Partnerships

John Hawkins
SVP, Advocacy & Public Policy
Texas Hospital Association

John Henderson
President/CEO
Texas Organization of Rural & Community Hospitals

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EXHIBIT B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

STATE OF TEXAS, TEXAS HEALTH AND HUMAN SERVICES COMMISSION,	§	
Plaintiffs,	§	Case No. 6:21-cv-00191
v.	§	
CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the Department of Health and Human Services; the UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,	§	
Defendants.	§	

DECLARATION OF VICTORIA GRADY

STATE OF TEXAS §
COUNTY OF TRAVIS §

I, Victoria Grady, do hereby swear, affirm, and attest as follows, based upon my personal knowledge of the matters contained herein:

1. My name is Victoria Grady, I am over 18 years of age, of sound mind, and capable of making this declaration. I have personal knowledge of the facts stated

herein and they are true and correct. I would testify to the facts stated in this declaration in open court if called upon to do so.

2. I currently work as the Director of Provider Finance for the Texas Health and Human Services Commission (HHSC) and have oversight of the Provider Finance Department. I've held this position since September 24, 2018. Before that, I was the Deputy Director of Provider Finance, Senior Advisor to the Director of Provider Finance, and Government Relations Specialist for Finance. I have worked at HHSC since 2014.

3. The pending CHIRP, TIPPS, and RAPPS programs operate as directed payments to Medicaid managed care organizations (MCOs), or health plans, who make additional payments to providers beyond the contractual rate between the MCO and the provider, at the state's direction. Texas makes an additional payment on a per member per month basis to the MCO for each Medicaid client who receives coverage from the MCO. Texas can only direct those payments after receiving prior written approval of the programs from the Centers for Medicare and Medicaid Services (CMS). Without the additional funds being paid to the MCOs, the MCOs do not have resources to make the state directed payments to providers. Due to technological and operational requirements to administer Medicaid managed care and make billions of dollars of payments to MCOs each month, the MCO payment rates must be put into the payment system by approximately the 5th date of each month for payment for the subsequent month. For example, to issue MCO payments in February, HHSC must load into the payment system rates by January 1, or to make payments in March, HHSC must load the rates into the payment system by February 1. Prior to loading the rates, HHSC must have advance notice to allow for system entry and testing.

4. CMS has continued to withhold approval of CHIRP, TIPPS, and RAPPS. As a result, Texas hospitals, physicians, and rural health clinics enrolled in CHIRP, TIPPS, and RAPPS, respectively, will be without these critical payments for at least six months while battling another wave of COVID-19. More specifically, HHSC is unable to prepare the MCO rates to issue MCO payments for February, and the earliest possible date for payments to begin is now March 1, 2022.

5. Texas Medicaid providers are experiencing extreme duress due to the absence of these payments. Since September 2021 when UHRIP ceased and authority for the DSRIP pool expired, Texas has faced the surge of COVID-19's Delta variant and now another emerging surge of COVID-19's Omicron variant. The Delta surge did not dissipate until early November in Texas; the surge associated with Omicron began in Texas in early December and is not forecasted to peak until late January or mid-February. Providers caring for patients amidst these surges are grappling with a healthcare staffing crisis that has been directly caused by COVID-19 and is getting worse with each passing month. Providers increasingly state to me that they are unable to sustain staffing costs and, with increased costs for goods and supplies,

they are fearful that they will exhaust their ability to continue to provide care for Medicaid beneficiaries.

6. Providers in our medically under-served regions in Texas (like the Rio Grande Valley and rural communities) have indicated that they are at risk of closure if a solution is not found quickly. In particular, representatives for rural hospitals and rural health clinics, including providers in northeast Texas, have indicated that they are in immediate jeopardy. If these providers close, the closure is likely to be permanent, as I explained in prior declarations. *See, e.g.*, ECF 34-2 ¶ 17.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Travis County, State of Texas, on the 6th day of January 2022.

Victoria Grady

Victoria Grady