UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES 200 Independence Avenue, SW Washington, DC 20201 and XAVIER BECERRA Secretary of the United States Department of Health and Human Services, in his official capacity, 200 Independence Avenue, SW Washington, DC 20201 Defendants.	)	Case No. 21-cv-21616

COMPLAINT

INTRODUCTION

1. The Florida Agency for Health Care Administration ("AHCA," "Florida," or "the State"), seeks review of a final administrative decision by the United States Department of Health and Human Services ("HHS") Departmental Appeals Board ("Board") disallowing $97,570,183 in federal reimbursement for certain payments that the State made to hospitals and other health care providers through the Medicaid program from July 1, 2006 to June 30, 2013 (State Fiscal Years ("SFYs") 2007 – 2013, also known as Demonstration Years ("DYs") 1-7). The disallowance was taken by the Centers for Medicare & Medicaid Services ("CMS"), which is the constituent agency within HHS tasked with oversight of the Medicaid program.

2. The dispute involves the interplay between two types of Medicaid payments that AHCA makes for which it is entitled to federal reimbursement: Disproportionate Share Hospital ("DSH") payments and Low-Income Pool ("LIP") payments.

3. Both DSH and LIP payments are intended to provide additional support to hospitals that provide services to the State's most vulnerable populations. In this case, almost all of the funds that HHS seeks to recover involve payments to Jackson Memorial Hospital, the State's largest provider of safety net services to Medicaid patients, the uninsured, and the underinsured.

4. DSH payments are authorized under Title XIX of the Social Security Act ("SSA"), but each State is limited in the amount of DSH payments that it can distribute. First, each hospital has a "hospital-specific" DSH cap, which limits the amount of DSH payments that a state can make to a specific hospital for the costs incurred by the hospital in furnishing inpatient and outpatient services to Medicaid-eligible individuals and the uninsured, after deductions of Medicaid payments. 42 U.S.C. § 1396r-4(g). Second, federal law imposes an annual aggregate cap on the amount of DSH payments that each state can distribute to hospitals. 42 U.S.C. § 1396r-4(f).

5. LIP payments are authorized under the special terms and conditions of Florida's "demonstration project" or "waiver" that the Secretary of HHS first approved in 2005, effective in 2006, pursuant to Section 1115 of the Social Security Act, 42 U.S.C. § 1316. Like DSH, the purpose of LIP payments during the time period at issue is to "ensure continued government support for the provision of health care services to Medicaid, underinsured, and uninsured populations."

6. Like DSH, LIP has a provider-specific cap equal to the costs of medical services for Medicaid patients and the underinsured, net of Medicaid payments. Also, like DSH, LIP payments are subject to an annual aggregate cap. In addition, LIP permitted inclusion of costs of medical services related to underinsured patients.

7. From its inception, the purpose of the LIP program has been to provide support to hospitals and other providers beyond the DSH caps, and LIP was intended to be more flexible than DSH. However, HHS is now taking the position that a hospital's uncompensated costs must be calculated for LIP purposes using a much more conservative methodology than the Medicaid statute permitted the State to use to calculate uncompensated costs for DSH purposes during the same period. This does not make any sense, and it is inconsistent with both the terms of the Section 1115 demonstration project and the Medicaid statute. The HHS Departmental Appeals Board's decision upholding the disallowance of $97,570,183 in federal funds is arbitrary, capricious, an abuse of discretion, and not in accordance with the text or the purpose of Section 1115 of the Social Security Act or the terms and conditions of Florida's Section 1115 demonstration project. The Court should set aside the Board's decision and the underlying disallowance.

JURISDICTION AND VENUE

8. This action arises under Section 1116 of the Social Security Act, 42 U.S.C. § 1316(e)(2)(C), and Section 10 of the Administrative Procedures Act, 5 U.S.C. § 704. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1361.

9. Venue is proper under 28 U.S.C. § 1319(e)(1) and 42 U.S.C. § 1316(e)(2)(C).

PARTIES

10. Plaintiff Florida Agency for Health Care Administration is the "single State agency" responsible for administration of the State of Florida's participation in the federal Medicaid program. *See* 42 U.S.C. § 1396a(a)(5).

11. Defendant United States Department of Health and Human Services ("HHS"), through its constituent agency the Centers for Medicare & Medicaid Services, is the federal department responsible for administering the Medicaid program.

12. Defendant Xavier Becerra is the Secretary of HHS and is responsible for the overall administration of the agency. He is sued in his official capacity.

13. The HHS Departmental Appeals Board acts for the Secretary in disputes involving Medicaid disallowances. *See* 42 U.S.C. § 1316(e)(2)(A).

BACKGROUND

The Medicaid Program and Medicaid Funding

14. Medicaid is a cooperative federal-state program in which the federal government provides financial assistance to participating States in connection with the provision of health care – referred to as "medical assistance" – to lower-income individuals and families. Under the federal Medicaid statute (Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq*.), States are entitled to federal reimbursement for a percentage of their expenditures on medical assistance made pursuant to a state plan approved by CMS. *See id*. § 1396a-b.

15. The federal government's share of a State's expenditures under the Medicaid program is called "federal financial participation" ("FFP"). 42 C.F.R. § 400.203.

16. Section 1115 of the SSA permits the Secretary, acting through CMS, to waive compliance with certain statutory requirements applicable to the Medicaid program to approve experimental, pilot or demonstration projects that, in the judgment of the Secretary, are likely

to assist in promoting the objectives of the Medicaid program. 42 U.S.C. § 1315. Expenditures authorized under a Section 1115 demonstration project are "regarded as expenditures under the state plan," and also qualify for federal financial participation. 42 U.S.C. § 1315(a)(2).

17. CMS's approval of a waiver under Section 1115 is subject to special terms and conditions that are negotiated between CMS and the State.

Medicaid DSH Payments

18. Since 1981, Section 1902(a)(13)(A)(iv) of the SSA has required that State Medicaid programs make Disproportionate Share Hospital or "DSH" payments to qualifying hospitals that serve a "disproportionate number of low-income patients with special needs." 42 U.S.C. § 1396a(a)(13)(A). The purpose of the DSH provision is to improve the financial stability of these hospitals and preserve access to quality health services for low-income patients. H.R. Rep. No. 97-208, at 962 (1981).

19. Section 1923 of the SSA establishes an annual "DSH allotment" for each State that limits the amount of federal financial participation for total statewide DSH payments made to hospitals. 42 U.S.C. § 1396r-4(f)(3).

20. Section 1923 also establishes a "hospital-specific" limit for DSH payments. 42 U.S.C. § 1396r-4(g)(1)(A). This provision is captioned "amount of adjustment subject to uncompensated costs." *Id.*

21. Section 1923(g)(1)(A) provides that DSH payments made to a hospital cannot exceed:

> The costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

22. In 2008, CMS by regulation defined the hospital-specific DSH limit as "total annual uncompensated care costs," to be calculated as follows:

> The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and Section 1011 payments. . . .

42 C.F.R. § 447.299(c)(16).

23. In 2017, CMS amended this rule to define the "total cost of care" for Medicaid inpatient and outpatient services as "net of third-party payments, including, but not limited to, payments by Medicare and private insurance." *See* 82 Fed. Reg. 16122 (Apr. 3, 2017).

24. Before amending its regulations, CMS had attempted to apply this definition of uncompensated care through a "frequently asked questions" guidance issued in 2010, in which CMS stated that third-party payments to hospitals must be deducted from costs in calculating the Medicaid "total cost of care." This requirement was contrary to the practice many States and hospitals had followed in calculating uncompensated costs and the hospital-specific DSH payment limit, and hospitals and hospital associations brought actions against CMS in a series of lawsuits across the country.

25. CMS's attempt to change the definition of uncompensated costs through "frequently asked questions" was uniformly rejected by courts as not independently required by the statute and violative of the notice-and-comment mandates of the Administrative Procedures Act. *See, e.g., Children's Hosp. of the King's Daughters v. Price*, 258 F. Supp. 3d 672, 682 (E.D. Va. 2017); *Tenn. Hosp. Ass'n v. Price*, 2017 WL 2703540 (M.D. Tenn. 2017); *Children's Health Care v. CMS*, 2017 WL 3668758 (D. Minn. 2017), *aff'd*, 900 F.3d 1022 (8th

Cir. 2018); *N.H. Hosp. Ass'n v. Burwell*, 2017 WL 822094 (D.N.H. 2017), *aff'd*, 887 F.3d 62 (1st Cir. 2018); *Tex. Children's Hosp. v. Burwell*, 76 F. Supp. 3d 224 (D.D.C. 2014).

26. In December 2018, CMS announced that, in light of these decisions, it was withdrawing its "frequently asked questions" and would not require third-party payments to be deducted from Medicaid costs in determining the hospital-specific DSH limit for any period prior to the effective date of its amended regulation, which was June 2, 2017. *See* CMS, Medicaid Bulletin, Updated FAQs: Additional Information on the DSH Reporting and Audit Requirements (Dec. 31, 2018) (attached as Exh. 1); *see also CMS*, Informational Bulletin, Treatment of Third Party Payers (TPP) in Calculating Uncompensated Care Costs (UCC), at 2 (Aug. 18, 2020) (attached as Exh. 2).

27. As a result, prior to June 2, 2017, a State could make Medicaid DSH payments to a hospital as long as the payments did not exceed a hospital-specific cap that was calculated as: costs of providing care to Medicaid patients and the uninsured, minus Medicaid payments and payments from uninsured persons.

Florida's Section 1115 Waiver to Implement Medicaid Reform

28. Based on its authority under Section 1115 of the SSA, HHS through CMS approved Florida's Medicaid Reform demonstration waiver ("demonstration" or "waiver") in 2005. The waiver began in 2006, and was extended in 2011, 2014, 2017, and 2021. It is now known as the Florida Managed Medical Assistance demonstration and is approved through June 30, 2030.

29. Structural changes to Florida's Medicaid program as part of the waiver had the potential to significantly reduce payments the State made to hospitals and other safety net care

providers to help cover some of the uncompensated costs these providers incurred in serving Medicaid, underinsured, and uninsured populations.

30. Therefore, the waiver project included a Low Income Pool ("LIP") to ensure "continued governmental support for the provision of health care services to Medicaid, underinsured and uninsured populations." CMS, Special Terms and Conditions (STC) for the Florida Medicaid Reform Section 1115 Demonstration, July 1, 2006 Through June 30, 2011, at STC 91 ("Original STCs") (attached as Exh. 3). The LIP program was intended to increase payments to providers for uncompensated care and expand the type of providers eligible to receive these payments. *Id*. at STC 94.

31. The Original STCs described LIP permissible expenditures as follows:

> Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS.

Id. at STC 97.

32. When the waiver was extended in 2011, the terms and conditions of the extension described LIP permissible expenditures as:

> Funds for the LIP may be used for health care costs (medical costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care costs may be incurred by the State, by hospitals, clinics, or by other provider types to furnish medical care for the uninsured and underinsured for which compensation is not available from other payors, including other Federal or State programs. Such costs may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and

> CMS. These health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments).

CMS, Special Terms and Conditions for the Florida Medicaid Reform Section 1115 Demonstration, Dec. 16, 2011 Through June 30, 2014, at STC 54 ("Extension STCs") (attached as Exh. 4).

33. The STCs also provided that the State would "not receive FFP for Medicaid and LIP payments to hospitals in excess of cost." Exh. 3, at STC 97; Exh. 4, at STC 57.

34. In order to comply with these provisions, the State required hospitals and other providers receiving LIP distributions to calculate a "LIP Cost Limit" according to a methodology set forth in a "Reimbursement and Funding Methodology Document" reviewed and approved by CMS.

35. Given the similarities between the DSH hospital-specific cap and the LIP Cost Limit, after CMS issued its "frequently asked questions" in 2010, most hospitals deducted third-party payments from Medicaid costs for purposes of the LIP calculation, as they had been instructed to do for DSH. This resulted in a lower LIP Cost Limit than would have been the case if third-party payments had not been deducted.

36. AHCA provided the results of the LIP Cost Limit calculations to CMS.

Disallowance

37. On September 28, 2016, CMS issued a disallowance in the amount of $146,113,363 in FFP, relating to LIP payments in excess of the calculated LIP Cost Limits for the first seven years of the Medicaid Reform waiver project (July 2006 through June 2013).

38. Florida sought reconsideration of the disallowance, and CMS revised the amount to $97,570,183 in FFP by letter dated January 19, 2017. The State timely appealed the revised disallowance to the Departmental Appeals Board.

39. As noted above, in December 2018, CMS rescinded its guidance requiring that third-party payments be deducted in establishing DSH hospital-specific limits for any period prior to June 2, 2017. *See* Exh. 1. However, it continued to take the position, in the Departmental Appeals Board action, that third-party payments should be deducted for purposes of determining the LIP cost limit. *See Florida Agency for Health Care Admin*., DAB No. 3031 (2021).

40. All of the disallowance period is before June 2, 2017.

Impact on Jackson Memorial Hospital

41. More than $92 million of the $97 million disallowance relates to LIP payments made to Jackson Memorial Hospital in 2012 and 2013. Jackson Memorial's DSH payments during those years did not exceed the calculated DSH limits, which were inclusive of LIP payments made to the hospital, indicating that the hospital incurred substantial uncompensated care as calculated following CMS guidelines for the period. The cost of this uncompensated care for each year exceeded both the LIP and DSH combined payments.

42. Jackson Memorial Hospital is part of Jackson Health, a public, non-profit tertiary care teaching hospital and health system located in Miami-Dade County, which is governed and operated by the Public Health Trust of Miami-Dade County pursuant to county ordinance and Florida law.

43. As a public hospital and health system, Jackson Health receives funding from Miami-Dade County to support its charitable mission to build the health of the community by

providing a single, high standard of quality care for the residents of Miami-Dade County regardless of their ability to pay for services. The funding Jackson Health receives is used to provide care for the underinsured and uninsured population in Miami-Dade County.

44. Jackson Memorial Hospital is closely affiliated with the University of Miami Health System, which owns and operates the University of Miami Hospital, the Anne Bates Leach Eye Hospital, and the University of Miami Hospitals and Clinics/Sylvester Comprehensive Cancer Center ("University of Miami Health System"). Jackson Memorial and the University of Miami Health System have a variety of arrangements designed to facilitate cooperation and coordination. For example:

a. Since 1952, the Public Health Trust has maintained an affiliation agreement with the University of Miami Leonard M. Miller School of Medicine, supplemented by an annual operating agreement, which together set forth the responsibilities of and the services to be provided by each party.

b. Jackson Memorial's graduate medical education program is predominantly staffed with residents from the University of Miami.

c. Of the nearly 1,000 full-time faculty members of the medical school, more than 600 are doctors engaged in clinical practice who have been granted medical staff privileges and can admit patients to Jackson Memorial.

d. Jackson Memorial and the University of Miami Health System also cooperate in providing services in a number of specialized facilities and centers, including the Ryder Trauma Center, Holtz Children's Hospital, UM/JM Burn Center, Newborn Intensive Care Center, Jackson Transplant Center and Jackson Rehabilitation Hospital.

e. In addition, indigent Jackson Memorial patients receive ophthalmological services when needed through the Anne Bates Leach Eye Hospital.

45. The University of Miami Health Systems hospitals were paid well under their LIP Cost Limits during the years for which CMS alleges that Jackson received LIP overpayments.

46. Treating Jackson Memorial and the University of Miami Health System on a combined basis would result in aggregate LIP payments being less than aggregate LIP Cost Limits during the years at issue in the disallowance, even with the deduction of third-party payments that CMS advocates.

47. AHCA has interpreted the STCs as permitting it to consider the University of Miami Health System together with Jackson Memorial in determining Jackson Memorial's LIP payments and LIP Cost Limits because of the close integration of the services and programs between Jackson Memorial and the University of Miami Health System.

48. AHCA proposed this approach to CMS, who rejected it.

49. On March 29, 2019, while the disallowance was pending before the Departmental Appeals Board, the Public Health Trust of Miami-Dade County brought suit against HHS and its Secretary seeking to enjoin application of CMS's withdrawn guidance regarding third-party payors to Florida's LIP Cost Limit calculations as set forth in the disallowance. *See* Compl., *Public Health Trust of Miami-Dade County v. HHS*, Case No. 1:19-cv-21206-CMA (S.D. Fla. Mar. 29, 2019), Doc. 1. The Complaint noted that Jackson Health depends upon LIP payments to carry out its critical mission to provide health care to those most in need.

50. On August 2, 2019, U.S. District Court Judge Cecilia Altonaga issued an order dismissing the case for lack of subject matter jurisdiction, holding that because the Departmental Appeals Board had not yet ruled on Florida's appeal, the disallowance "[fell]

short of final agency action subject to APA review," because "reversal of the policy is still possible." *See* Order at 10, *Public Health Trust of Miami-Dade County*, Case No. 1:19-cv-21206-CMA, Doc. 50.

51. The court noted that "[i]f the appeal is concluded and the disallowance affirmed, Florida may still seek judicial review of that decision under 42 U.S.C. section 1316(e), further delaying any injury to Plaintiff." Order at 10.

The Departmental Appeals Board Disallowance Decision

52. On February 25, 2021, the HHS Departmental Appeals Board issued a decision sustaining the disallowance of $97,570,183 in FFP for LIP payments in excess of costs during DYs 1-7. *See Florida Agency for Health Care Admin*., DAB No. 3031 (2021). In its decision, the Board agreed with CMS that the STCs require that the cost of uncompensated care for Medicaid patients, as well as for the uninsured and underinsured, must be offset by third-party payments, including from Medicare, in calculating the LIP Cost Limits. *Id*.

53. The Board reached this decision even though the STCs, like the DSH statute, only specify the deduction of Medicaid payments from Medicaid costs. *Id*.

54. Under the decision of the Departmental Appeals Board, funds that Jackson Memorial is entitled to keep under its DSH calculation are considered overpayments subject to recoupment under the LIP Cost Limit Calculation. *Id*.

55. The Board also held that the STCs do not allow Florida to consider Jackson Memorial Hospital's LIP Cost Limit and payments in conjunction with the University of Miami Health System hospitals' LIP Cost Limit and payments to determine if the cost limit was exceeded. *Id*.

COUNT I

(Administrative Procedure Act: Violation of the Social Security Act and Arbitrary and Capricious Agency Action)

1. Paragraphs 1 through 55 above are incorporated herein by reference.

2. The decision that the terms and conditions of Florida's Section 1115 waiver project require the State in calculating the LIP Cost Limit, to offset the uncompensated cost of providing care to Medicaid patients by deducting third-party payments, including from Medicare, is arbitrary and capricious, an abuse of discretion, and contrary to law.

COUNT II

(Administrative Procedure Act: Violation of the Social Security Act and Arbitrary and Capricious Agency Action)

3. Paragraphs 1 through 55 above are incorporated herein by reference.

4. The decision that the terms and conditions of Florida's Section 1115 waiver project prohibit the State from considering Jackson Memorial Hospital and the University of Miami Health System hospitals together for purposes of calculating the LIP Cost Limit is arbitrary and capricious, an abuse of discretion, and contrary to law.

REQUEST FOR RELIEF

WHEREFORE, Plaintiff the Florida Agency for Health Care Administration requests that this Court grant the following relief:

A. Set aside HHS Departmental Appeals Board Decision No. 3031, and the underlying disallowance upheld by that decision;

B. Permanently enjoin Defendants and their agents, employees, successors in office, and all persons acting in concert or participation with them, from disallowing the $97,570,183 at issue;

C. Award Florida such declaratory and other relief as may be just and proper;

D. Retain jurisdiction over this action for such additional and supplemental relief as may be required to enforce the order and judgement.

Respectfully Submitted,

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