IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

TEXAS HEALTH AND HUMAN SERVICES COMMISSION,	§	
	§	
Plaintiff,	§	
	§	
v.	§	Civil Action No. 3:19-cv-2857
	§	
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND	§	
	§	
ALEX M. AZAR II, SECRETARY OF HEALTH AND HUMAN SERVICES,	§	
	§	
Defendants.	§	

PLAINTIFF'S ORIGINAL COMPLAINT

A. INTRODUCTION

1. Plaintiff, the Texas Health and Human Services Commission (Texas HHSC), seeks reversal of the United States Department of Health and Human Services' (HHS) unlawful decision requiring Texas HHSC to repay tens of millions of dollars in federal financial participation (FFP) in supplemental Medicaid payments.
2. This Complaint seeks judicial review of Decision No. 2886 issued on August 7, 2018 by the HHS Departmental Appeals Board (DAB) and attached hereto as **Exhibit A**. 5 U.S.C. Ch. 7; 42 U.S.C. § 1316(e)(2)(C). That decision sustained a disallowance by the Centers for Medicare & Medicaid Services (CMS) of $25,276,116 in Medicaid supplemental payments to certain private hospitals in Texas.

3. The DAB denied reconsideration of its decision on October 2, 2019 in Ruling No. 2020-1, attached hereto as **Exhibit B**, and Texas HHSC timely filed this Complaint seeking judicial review of the DAB's final decision sustaining the disallowance. 42 U.S.C. § 1316(e)(2)(C).

B. PARTIES

4. Plaintiff is the Texas Health and Human Services Commission. Texas HHSC is the state agency that administers the Medicaid program in the State of Texas.
5. Defendants are the United States Department of Health and Human Services and Alex M. Azar II, in his official capacity as Secretary of HHS. HHS is the federal agency responsible for administering the Medicaid program, which it does through CMS.

C. JURISDICTION

6. Texas HHSC is entitled to judicial review of CMS's disallowance decision pursuant to 5 U.S.C. Ch. 7 and 42 U.S.C. § 1316(e)(2)(C). CMS's decision constitutes a "final agency action" within the meaning of 5 U.S.C. § 704.
7. This Court has jurisdiction pursuant to 28 U.S.C. § 1331, which provides for original jurisdiction in suits involving questions arising under federal law.
8. The Court has authority to grant declaratory relief pursuant to 28 U.S.C. § 2201 and 5 U.S.C. § 706.

D. VENUE

9. Venue is proper under 42 U.S.C. § 1316(e)(2)(C), which authorizes Texas HHSC to seek judicial review of CMS's final decision sustaining the disallowance in any United States District court within Texas.

E. FACTS

Medicaid Program

10. Medicaid is a joint federal-state healthcare program in which states provide a level of funding that is supplemented by financial assistance from the federal government. 42 U.S.C. §§ 1396(a)–(f)(4).

11. Each state, through either state or local government entity funds, provides at least 40 percent of each Medicaid dollar expended within the state (state share). 42 U.S.C. § 1396a(a)(2). Each state receives federal matching funds (federal share or FFP). 42 C.F.R. §§ 400.203, 430.1 and 45 C.F.R. § 95.4.

12. Texas participates in the Medicaid program under the State Plan and a section 1115 waiver, developed by the Texas HHSC and approved by CMS. 42 U.S.C. §§ 1315, 1396a; 42 C.F.R. §§ 430.10-430.25.

Hospital Medicaid Supplemental Payments in Texas

13. As is true in many states, for hospitals in Texas, reimbursement for healthcare services furnished to Medicaid patients is insufficient to cover the providers' costs.

14. Federal law permits states to supplement a Medicaid agency's payments for services provided by hospitals. Neither supplemental Medicaid payments nor base payments for Medicaid services may include improper provider-related donations, described further below.

15. In the Uncompensated Care program, one of the programs administered by Texas HHSC to provide hospital supplemental payments, the state share of the Medicaid

supplemental payments for non-state entities is transferred to Texas HHSC from local governmental units.

16. In Dallas and Tarrant Counties, a large portion of the state share comes from the counties' respective hospital districts.

17. In 2007, certain private hospitals and hospital systems located in Dallas County formed the Dallas County Indigent Care Corporation (DCICC), and private hospitals in Tarrant County formed the Tarrant County Indigent Care Corporation (TCICC). Both the DCICC and TCICC were designated as 501(c)(3) entities with the stated purpose of providing or arranging for healthcare for their respective county's indigent populations.

18. The private hospital members of DCICC and TCICC (affiliated hospitals), through these corporations, contracted with physician groups to provide services to indigent patients at the Dallas County Hospital District facility and the Tarrant County Hospital District facility.

Provider Related Donations Regulation

19. The Social Security Act (the Act) requires total expenditures for medical assistance in which a state claims FFP be reduced by the sum of any revenues received by the state in the form of impermissible provider-related donations. 42 U.S.C. § 1396b(w)(1)(A).

20. The Act defines "provider-related donation" as any donation or other voluntary payment (in-cash or in-kind) made directly or indirectly to a state or unit of local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the state plan and paid as administrative expenses. 42 U.S.C. § 1396b(w)(2)(A).

21. A state may receive provider-related donations without a reduction in FFP if the statutory requirements pertaining to bona fide donations are met. 42 U.S.C. § 1396b(w)(1)(A). 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. 42 U.S.C. § 1396b(w)(2)(B).

22. CMS's predecessor, the Health Care Financing Administration (HCFA), implemented this statutory language through rulemaking in 1993. Under the applicable regulations, donations made by a health care provider to an organization, which in turn donates money to the state, may be considered indirect donations to the state by the health care provider. 42 C.F.R. § 433.52 (provider-related donation). HCFA defined bona fide donations in accordance with the Social Security Act: a bona fide donation is a provider-related donation that has no direct or indirect relationship to Medicaid payments to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity as established by the state to the satisfaction of the Secretary. 42 C.F.R. § 433.54(a). 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. 42 C.F.R. § 433.54(b).

23. 42 C.F.R. § 433.54(c) describes under what circumstances a hold harmless practice exists in the context of bona fide donations. Under § 433.54(c), a hold harmless practice exists if any of the following applies:

a. (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 correlated to the donation. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

b. (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.

c. (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).

2008 Rulemaking

24. In 2008, CMS issued a final rulemaking action titled "Medicaid Program; Health Care-Related Taxes." In it, CMS revised 42 C.F.R. § 433.68(f), which addresses hold harmless arrangements in the context of health care-related taxes, and 42 C.F.R. § 433.54(c), which addresses hold harmless arrangements in the context of bona fide donations. In the preamble or 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)." 73 Fed. Reg. 9685-01. The "reasonable

expectation" standard described in the summary of § 433.68(f)(3) was not part of the revisions CMS made to that regulation or to § 433.54(c)(3).

25. While the "Medicaid Program; Health Care-Related Taxes" rulemaking action amended 42 C.F.R. § 433.54(c), the "reasonable expectation" standard was not part of those amendments. Moreover, CMS's summary of the "reasonable expectation" standard was solely in the context of health care-related taxes and did not specify that standard would apply to § 433.54(c).

State Medicaid Director Letter 14-004

26. On May 9, 2014, CMS released State Medicaid Director Letter #14-004 (SMDL 14-004), which purported to "clarify" prior guidance by describing collaborative charity care arrangements as improper. This was a reversal of agency position.

27. The "reasonable expectation" standard did not appear in SMDL 14-004.

CMS 2016 Disallowance

28. On September 1, 2016, CMS notified Texas HHSC that it disallowed $26,844,551 in federal share uncompensated care payments to private hospitals in Dallas and Tarrant counties for the fourth quarter of federal fiscal year 2015. 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.

29. October 28, 2016, Texas HHSC sent a written request to the CMS Administrator to reconsider and reverse the disallowance decision. By email dated December 29, 2016, CMS notified Texas that the disallowance was affirmed.

30. HHSC timely appealed the final disallowance decision of CMS to the DAB pursuant to 42 U.S.C. § 1316 and 45 C.F.R. §§ 16.1–.23.

31. Certain private hospitals in Dallas and Tarrant Counties that received supplemental Medicaid payments sought and received permission to participate in the DAB proceeding as Intervenors, including Baylor Health Care System, Methodist Hospitals of Dallas, Texas Health Resources, and North Texas Division, Inc.

DAB Rulings

32. The DAB affirmed the disallowance by decision dated August 7, 2018, opining that the private hospitals were held harmless because they had a reasonable expectation that they would receive an offsetting government payment. The DAB decision reduced the disallowance amount to $25,276,116.

33. The DAB also concluded that it didn't even need to apply the "reasonable expectations" standard (that CMS first noted in response to comments on 2008 rulemaking) because the "net effect" of the arrangements amounted to impermissible provider donations.

34. The "net effect" standard did not appear in SMDL 14-004.

35. The DAB rejected arguments made by Texas HHSC and Intervenors, including:

    a. The recipients of the physician services were the indigent patients not the county hospital districts;

    b. The county hospital districts had no legal or contractual obligation to provide these physician services, so the affiliated hospitals were not relieving the county hospital districts of legal or contractual obligations by undertaking them and therefore could not be found to be making a provider donation; and

c. The state had no notice that CMS interpreted provider donations so broadly as to encompass any indirect transfer of value in the form of the provision of services.

36. HHSC and the Intervenors filed a joint motion for reconsideration and reversal, which the DAB denied on October 2, 2019.

CMS Proposed Rulemaking

37. On November 18, 2019, CMS published in the Federal Register a proposed rulemaking action titled "Medicaid Fiscal Accountability Regulation." 84 Fed. Reg. 63722. This extensive proposal addresses provider-related donations and purports to codify the "net effect" and the "reasonable expectation" standards.

38. CMS states in the November 2019 proposal that "[i]n line with the Board's reasoning, we are proposing to establish a net effect standard to look at the overall arrangement in terms of the totality of circumstances to judge if a non-bona fide donation . . . has occurred." *Id*. at 63736.

39. The November 2019 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." *Id*. at 63738. 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." *Id*. at 63739.

F. COUNT I

40. The DAB's final decision affirming the disallowance should be declared unlawful and set aside pursuant to 5 U.S.C. § 706(2) because the decision is arbitrary and capricious,

an abuse of discretion, in excess of and not in accordance with law, made without observance of procedure required by law, and unsupported by substantial evidence.

41. The DAB lacked the authority to apply the "net effect" or the "reasonable expectation" standards. The standards were inconsistent with CMS's established regulations and practices and did not appear in the statute or regulation at the time of the disallowance or the DAB decision. Recent proposed rulemaking by CMS that would codify these standards demonstrates that the agency lacked the authority to enforce the standards against Texas. That CMS has proposed to now establish the "net effect" and the "reasonable expectation" standards in regulation demonstrates that the DAB did not correctly interpret the provider-related donation regulation. If CMS intends to impose a condition on the grant of federal moneys, it must do so unambiguously. *Hawaii Department of Human Services et al*, Ruling on Request for Reconsideration, DAB No. 1981, issued February 22, 2006 (citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17 (1981)). The "net effect" and "reasonable expectation" standards should only be implemented after notice and comment rulemaking as required under the Administrative Procedure Act (APA), 5 U.S.C. § 553.

42. Rather than rely on the provider-related donation statutory and regulatory requirements, the DAB also incorrectly relied on the "reasonable expectation" standard set out in the preamble to an unrelated 2008 provider tax regulation to find an impermissible hold harmless arrangement. CMS failed to provide notice to the State that the "reasonable expectation" standard would also be applied to the provider-related donation regulation. Application of the "reasonable expectation" standard constituted legislative rulemaking

and should have been preceded by notice and comment as required by the APA. *See* 5 U.S.C. § 553.

43. CMS impermissibly based the disallowance on SMDL #14-004. This State Medicaid Director letter was a new and expanded interpretation of the provider-related donation regulation, issued without notice and comment rulemaking. CMS's issuance of SMDL 14-004 constituted legislative rulemaking and should have been preceded by notice and comment as required by the APA. *See* 5 U.S.C. § 553. The DAB acted in excess of its authority and without observance of rulemaking procedure in applying this letter to the uncompensated care payments at issue to affirm the disallowance thereof.

44. The DAB erred in its application of state law by finding that the affiliated hospitals assumed a local government entity's statutory obligation to provide or pay for indigent care when other sources of payment for care were available. The finding is contrary to Texas law, which provides that local government entities are the payors of last resort, obligated to provide or pay for indigent care only if no other entity is providing or paying for it. Tex. Health & Safety Code § 61.022(b). Texas law does not require local government entities to provide health care assistance to all residents. *Id*.

45. The DAB also erred in finding that DCICC and TCICC "staff" the public hospitals by providing for physician services for indigent patients at the public hospitals. Unlike nurses, technicians, case workers, and others who form the "staff" of a hospital for purposes of the hospital's ability to provide the technical component of care, physicians use hospital facilities to deliver care to patients, provided they have obtained the proper medical staff privileges.

G. PRAYER

46. The Texas Health and Human Services Commission prays that this Honorable Court:

a. Set aside and reverse the DAB's decision affirming the disallowance;

b. Enter a declaration, pursuant to 28 U.S.C. § 2201, that CMS's disallowance of $25,276,116 was arbitrary, capricious, an abuse of discretion, not in accordance with law, and is invalid under the 5 U.S.C. § 706(2);

c. Enter a declaration, pursuant to 28 U.S.C. § 2201, that the DAB's announcement of the "net effect" and "reasonable expectation" standards in its decision was made without satisfying the notice and comment requirement of 5 U.S.C. § 553;

d. Enter a declaration, pursuant to 28 U.S.C. § 2201, that CMS issued SMDL 14-004 without satisfying the notice and comment requirement of 5 U.S.C. § 553; and

e. Award such other and further relief as this Court deems appropriate.

Respectfully submitted,

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DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

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BY DAB E-FILE

August 8, 2018

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Re: Decision in the Appeal of Texas Health and Human Services Commission
Docket No. A-17-51
Decision No. 2886
Dated: August 7, 2018

Counsel:

Enclosed is a copy of the decision of the Departmental Appeals Board in the appeal identified above.

This decision is the final decision of the Secretary unless, within 60 days of the date of this decision, a party files a motion for reconsideration by the Board. If no motion for reconsideration is filed within that 60-day period, the State may obtain judicial review by filing, within that 60-day period, an action in any United States District Court located within the State or in the United States District Court for the District of Columbia. *See* 42 U.S.C. § 1316(e)(2)(B), (C).

Sincerely yours,

/s/ *Judith Pichler*

Judith Pichler
Deputy Director, Appellate Division

Enclosure

cc: Office of Financial Management, CMS

Center for Medicaid and CHIP Services, CMS

Office of the General Counsel, CMS Division

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Texas Health and Human Services Commission
Docket No. A-17-51
Decision No. 2886
August 7, 2018

DECISION

The Texas Health and Human Services Commission (Texas or State) appeals the determination of the Centers for Medicare & Medicaid Services (CMS) disallowing $26,844,551 in federal financial participation (FFP) in supplemental Medicaid payments made to certain private hospitals for the quarter ending December 31, 2015. The disallowance was based on CMS's finding that the state share of the supplemental payments was derived from impermissible provider 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 (County HDs). The private hospitals involved in these arrangements sought and received permission to participate in these proceedings as Intervenors and have submitted briefing and exhibits, as have Texas and CMS.

As explained below, we find that the financing arrangements disclosed in the record before us constitute provider donations triggering intergovernmental transfers (IGTs) by the County HDs to the State's Medicaid agency. The IGTs were designed to and did finance the State's share of supplemental Medicaid payments then made to the same private hospitals making the donations in roughly the same amounts. We also find that the private hospitals and County HDs made their respective donations and transfers in expectation of and reliance on their use to draw down FFP which thereby covered virtually the full amount of the supplemental payments to be made to those private hospitals. We conclude that, in this scenario, CMS properly disallowed FFP in the supplemental payments because the State's share of those supplemental payments was financed by impermissible provider donations.

We sustain the disallowance determination but reduce the amount to $25,276,116 to reflect actual, rather than estimated, expenditures for the quarter at issue.

I. Applicable legal authorities

The permissible sources of financing of a state's share of Medicaid costs have been a longstanding point of contention between CMS and various states and the subject of a complex history of legislative, regulatory and administrative actions, including multiple Board decisions. We summarize here for context but do not exhaustively detail the full history.

A. Statutory restrictions on sources of state financing of Medicaid

The federal Medicaid statute, title XIX of the Social Security Act (Act),[1] provides for joint federal and state financing of medical assistance for certain needy and disabled persons. Act §§ 1901, 1903; 42 C.F.R. § 430.0. Each state that chooses to participate administers its own Medicaid program under broad federal requirements and the terms of its own "plan for medical assistance" (state plan) which must be approved by CMS. Act § 1902; 42 C.F.R. Part 430, Subpart B (state plan provisions). Thus, Medicaid is designed as "a partnership between the federal government and individual states" in which each shares in the cost of the program pursuant to formulae established in the Medicaid statute and regulations. *Ga. Dep't of Cmty. Health*, DAB No. 1973, at 1 (2005) (*Georgia*). In order to receive FFP in its expenditures for medical assistance, therefore, a state must cover its assigned share (sometimes called the non-federal share) of those expenditures, which varies from state to state (depending on a state's federal medical assistance percentage). Act § 1903(a)(1).[2] A state must finance at least 40 percent of the non-federal share from state funds, while the remainder may be drawn from sources such as local government contributions. Act § 1902(a)(2).

Beginning in the 1980s, many states sought to finance rising Medicaid costs through a variety of mechanisms drawing on sources outside the state budget, and after considerable controversy, Congress took action in the early 1990s to reduce the impact of some of these funding mechanisms on federal Medicaid expenditures. For background on that controversy, *see, e.g.,* Hearings on State Financing of Medicaid, House Comm. on Energy and Commerce, 102d Cong., 1st Sess. (Sept. 30, Oct. 16, and Nov. 25, 1991). An

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[1] The current version of the Act is available at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. A cross-reference table for the Act and the United States Code is available at https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

[2] The payments at issue in this case were expenditures for medical assistance, so we do not address other cost-sharing provisions under Medicaid, such as those relating to administrative costs.

initial effort by CMS to restrict such funding by regulation was overturned by a House moratorium, but Congressional concerns eventually led to restrictive statutory changes. The legislative history leading to those changes set out the core of this concern as follows:

> Although donation and tax programs vary from State to State, they all alter the Medicaid matching rate in basically the same way. These programs typically work as follows: (1) States "borrow" money from providers (usually hospitals) through donations or tax programs; (2) this money is then used as the State share of Medicaid and is matched, at least dollar for dollar, by Federal funds; (3) States frequently increase Medicaid payments to reimburse providers for the donations or taxes they paid; and (4) then States use the Federal matching funds to pay providers for the Medicaid services. In many States, providers are guaranteed to get back at least as much as they donated or paid in provider-specific taxes through enhanced Medicaid reimbursements.

H.R. Rep. No. 310, at 30 (Nov. 12, 1991), reprinted in 1991 U.S.C.C.A.N. 1413, 1439, quoted in *Georgia* at 13 (also citing 137 Cong. Rec. S18145-46 (Nov. 25, 1991) (statement of Sen. Durenberger); 137 Cong. Rec. H10520 (Nov. 19, 1991) (statement of Rep. Dannemeyer); 137 Cong. Rec. S18170-71 (Nov. 26, 1991) (statement of Sen. Grassley)).

The resulting Medicaid Voluntary Contribution and Provider-Specific Tax Amendments, P.L. No. 102-234 (1991), amended the Act to place limitations on state use of funds derived from either certain provider donations or certain taxes targeted at Medicaid providers. The relevant provisions of section 1903(w) of the Act currently read as follows:

> (1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State . . . for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan . . . shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—
>
> (i) from **provider-related donations (as defined in paragraph (2)(A)), other than –**
>
> **(I) bona fide provider-related donations** (as defined in paragraph (2)(B)), and
> (II) donations described in paragraph (2)(C);

* * *

> (2)(A) In this subsection . . . , the term "provider-related donation" means **any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly)** to a State or unit of local government by –
>
> (i) a health care provider (as defined in paragraph (7)(B)),
> (ii) an entity related to a health care provider (as defined in paragraph (7)(C)), ...

(Emphasis added.) Paragraph (2)(B) of section 1903(w) defines "bona fide provider-related donation" as "a provider-related donation that has no direct or indirect relationship (as determined by the Secretary [of Health and Human Services]) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary." It also provides that the Secretary "may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations." Paragraph (2)(C) permits donations related to stationing agency eligibility workers at hospitals or other providers and is not relevant to this case.

B. Regulatory implementation, interpretation, and application of those restrictions

Implementing regulations (in effect during the quarter at issue) require CMS to –

> deduct from a State's expenditures for medical assistance, before calculating FFP, funds from provider-related donations . . . received by a State or unit of local government, in accordance with the requirements, conditions, and limitations of this subpart, if the donations and taxes are not –
>
> (a) Permissible provider-related donations, as specified in § 433.66(b); or
>
> (b) Health care-related taxes, as specified in § 433.68(b).

42 C.F.R. § 433.57. The only permissible provider-related donations under section 433.66(b) (other than those relating to outstationed eligibility workers) are those that constitute "bona fide donations," defined in turn in section 433.54(a) as those that have "no direct or indirect relationship" to Medicaid payments made to the donating provider or any related entity. Section 433.54 (with emphases added) then explains how such a relationship is to be determined:

(b) Provider-related donations will be determined to 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 provision or practice, as described in paragraph (c) of this section.

(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 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).

CMS recognized that, while the statutory restrictions on provider-derived taxes in section 1903(w)(1)(A) of the Act spells out the requirement that the provider not be held harmless by the governmental entity for the amounts paid, the restrictions on provider donations in section 1903(w)(2)(B) of the Act left it to the Secretary to determine what constituted bona fide donations. In the preamble adopting section 433.54, therefore, CMS explained that the tax and donation provisions would be interpreted consistently:

In defining the conditions under which a State or local government receiving a provider-related donation is determined to hold providers harmless for such donations, we have adopted the same statutory tests of hold harmless that apply to health care-related taxes. We believe that use of the same tests establish continuity and consistency in the treatment of funding sources addressed in this interim final rule. Moreover, although we

> considered developing a separate test for determining when States' payments are related to provider donations, we believe the tests designated in the law for determining when States' payments hold taxpayers harmless for their tax costs are equally useful for this purpose.

57 Fed. Reg. 55,118, 55,120 (Nov. 24, 1992) (interim final rule).[3]

The Board has previously summarized the net effect of these legal provisions as follows:

> The Medicaid statute permits each state to look to state and local governmental sources as a funding source for the state or non-federal share of Medicaid costs. In 1991 Congress restricted a state's ability to receive conditional donations of funds from Medicaid providers as a funding source for the non-federal share when the donations are tied to the amount of reimbursement the providers receive.

Georgia at 1.

As the Board also discussed in *Georgia*, the Act provides an exception to the requirement that CMS reduce FFP by the amount of revenues the state receives from certain provider donations. Section 1903(w)(6) provides in relevant part:

> (A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes . . . transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2),[4] unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

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[3] We also note that section 1903(d)(6)(A)(i) of the Act requires states to report all "provider-related donations made to the State or units of local government" during the preceding fiscal year. Implementing regulations include more detailed reporting requirements, specifying quarterly submission of "summary information on the source and use of all provider-related donations (including all bona fide and presumed-to-be bona fide donations) received by the State or unit of local government" in reports that "must present a complete, accurate, and full disclosure of all of [the State's] donation and tax programs and expenditures." 42 C.F.R. § 433.74(a).

[4] Section 1902(a)(2) is the requirement that the state itself contribute at least 40 percent of the non-federal share from state funds.

> (B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

Such payments, or IGTs, by local government units (including such units as county hospital districts) were traditional sources of participation in Medicaid costs. Section 1903(w)(6) protects IGTs as long as they are not themselves derived from impermissible donations or taxes. The regulation implementing this provision reads as follows (at all relevant times):

> (a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.
>
> (b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
>
> (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

42 C.F.R. § 433.51 ("Public Funds as the State share of federal financial participation").

On May 14, 2014, CMS issued a State Medicaid Directors Letter (SMDL 14-004) which offered guidance on how CMS interpreted and applied the statutory and regulatory restrictions on the use of provider donations to finance Medicaid payments. Int. Ex. 1. SMDL 14-004 indicates that public-private arrangements of various kinds can be mutually beneficial and promote shared public and organizational purposes. *Id.* at 1. However, the letter explains, public-private partnerships in which "private entities provide a governmental entity with funds or other consideration and receive in return additional Medicaid payments typically in the form of a supplemental payment" would not be considered bona fide and therefore the resulting expenditures, such as supplemental payments, would not be allowable for FFP purposes. *Id.* at 1-2. That analysis would preclude partnerships in which the funds for IGT transfers to fund such payments are derived from the private entity taking over the expenditures for a service previously paid for by the public entity. *Id.* at 3. SMDL 14-004 provides illustrative examples, including the following which CMS describes as "analogous to the situation in this case" (CMS Br. at 10):

> Many of the proposed partnerships that CMS examined focus on the delivery of non-Medicaid services to non-Medicaid eligible individuals. One such proposed arrangement involved a government agency, a non-profit organization, and a private hospital. Under the arrangement, a government entity (other than the Medicaid agency) contracted with a non-profit organization to provide employment training and transportation to places of employment for individuals with disabilities. Under the terms of the proposed public-private partnership arrangement between the private hospital and a local government entity, the local government entity would terminate its existing contract with the non-profit organization. The private hospital would then execute the same contract with the same non-profit organization. The local government entity would send an IGT to the Medicaid agency, in an amount approximately equal to the amount that it would have spent on the now terminated contract, which would trigger a supplemental payment under the proposed [state plan amendment]. The supplemental payment would be directed to the private hospital that participates in public-private partnership arrangement. Under these circumstances, there is a hold harmless arrangement in which the contract to provide services is a provider-related donation and the receipt of supplemental payments is the return of some, or all, of the donation. As discussed below, this arrangement results in a non-bona fide donation and will not be approved by CMS unless claims for Federal Medicaid funding are reduced by the amount or value of the donation.

Id. at 4.

II. Case background

The public-private arrangements at issue in this appeal have developed over a number of years, and the parties characterize that development and the attendant communications between them very differently, while disagreeing little about the substance of the arrangements themselves. Texas views this disallowance as occurring "in spite of more than a decade of CMS approval and allowance of the very same funding arrangements." Tex. Br. at 1; *see also* Intervenors (Int.) Br. at 1 ("Contrary to a decade of consistent CMS determinations that these public/private collaborations comply with federal requirements, CMS now contends the collaborations are impermissible provider donations."). CMS, by contrast, describes a "longstanding dispute regarding the propriety" of those funding mechanisms, including four deferrals over the years, and repeated claims by the State that the arrangements had been "ostensibly modified," culminating in a 2014 financial management review by which "CMS's concerns were finally confirmed." CMS Br. at 1. Here, we identify the entities and relationships

involving the Affiliated Hospitals (AHs) and the County HDs; provide historical background on the origin of these arrangements in State plan amendments and the related history of interactions between the State and CMS about developing the financing model; explain the transition to the State's waiver demonstration program that was in operation during the quarter at issue; and summarize the financial management review that led to the deferral and disallowance now on appeal.

A. The Affiliated Hospitals and their arrangements with County HDs

Tarrant County and Dallas County Hospital Districts are the two County HDs involved in this case. The Intervenors[5] are private hospitals or hospital systems operating in those two counties, and each was among the private entities receiving supplemental payments from Medicaid in addition to their basic Medicaid payments for services provided. Motion to Intervene at 3. The Intervenors, along with other private hospitals, formed nonprofit corporations in 2007 in each county, the Dallas County Indigent Care Corporation (DCICC) and the Tarrant County Indigent Care Corporation (TCICC). *Id.* DCICC and TCICC received all of their funding from the private hospitals (that is, the AHs) involved in the arrangements at issue here, and it is undisputed that DCICC and TCICC constitute "related entities" to the hospitals for purposes of section 1903(w) of the Act and section 433.66(b) of the regulations.

During the relevant period, each hospital receiving supplemental payments had an agreement with one or both County HDs to serve as an AH. An affiliation agreement requires the AH to participate in the development of an indigent care plan and to "provide the Indigent Care" in accordance with that plan and with all applicable state and federal law, including Medicaid provisions. Tex. Ex. 2, at 12-13. The affiliation agreement in the record (for Dallas County) provides that the Dallas County HD "receives ad valorem tax revenues from property owners in the District and shall fund its obligations hereunder with such tax revenues." *Id.* at 12. The AHs agree to indemnify the County HD in the event that CMS denies some or all of the FFP related to the supplemental payments. *Id.* at 14. The County HD agrees to submit IGTs to the State "as the nonfederal share of the Dallas [supplemental hospital payments] . . . in the amount, if any, determined necessary in the final Indigent Care Plan for Medicaid services provided by the Affiliated Hospitals, and to report to each of the Affiliated Hospitals the amount submitted . . . ." *Id.* at 15. The affiliation agreement does not specify how the AHs are to provide medical care to indigent patients.

[5] Specifically, the Intervenors are Baylor Health Care System, Methodist Hospitals of Dallas, Texas Health Resources, and North Texas Division, Inc.

It is undisputed that, under Texas law, County HDs have an obligation to "endeavor to provide the basic health care services" for indigent residents required under the State's law and constitution and to do so "may appoint, contract for, or employ physicians." Tex. Br. at 21-22 (citing and quoting Tex. Health & Safety Code §§ 61.055, 281.0282(a), and 281.0286(a)) (internal quotation marks omitted). (Texas argues, however, that this obligation does not amount to a mandate to do more than meet the needs for indigent care that others are not providing. *Id.*)

It is also undisputed that the AHs, as tax-exempt non-profit organizations under Texas law, are required to provide unreimbursed "charity care" to indigent persons. *Id.* at 24-25 (and state law authorities cited therein).

B. Origin of the supplemental payments program – State plan amendments, approvals, deferrals, and communications between CMS and the State about financing

The AHs initially received supplemental payments under the Private Hospital Upper Payment Limit (UPL) program established by State plan amendments. The UPL program first arose under two State plan amendments that Texas submitted to CMS in 2005. Int. Ex. 2 (letter with Transmittal Number TX 05-001 attached) and Int. Ex. 3 (letter with Transmittal Number TX 05-011 attached). The proposed State plan amendments explain the funding of the State share of the costs for the supplemental payments to private hospitals as follows:

> Initial funding of the State share will be done through Intergovernmental Transfers from public hospital districts or counties identified in the State Plan Amendment. In subsequent years, Intergovernmental Transfers from recently created special tax districts will fund the State share. House Bill 2463, from the 79th Texas Legislature (2005), provides for the creation of these districts. [Int. Ex. 2, at 10.]

> The state share of funds used to draw down federal funds for Texas Medicaid Supplemental Inpatient and Outpatient payments comes from intergovernmental transfers from public hospitals, hospital districts, or other public entities. The state and federal funds are then used to reimburse non-state hospitals participating in the currently approved supplemental payment plans. [Int. Ex. 3, at 6.]

CMS raised questions during correspondence with the State in 2006 about the sources that local public entities would rely on to fund the IGTs called for in these State plan amendments. Among the exchanges was the following excerpt from a June 30, 2006 letter in which the State first quoted questions from CMS and offered its responses:

What is an indigent care agreement? Does this agreement require any transfer of funds between the hospital and the hospital district\local government? If so, please explain the requirement and describe both the amount and timing of the transfer. . . . What process does HHSC have in place to ensure there are no transfers of funds from the provider to the district/local government? Please note any transfer of funds would be an impermissible provider related donation. CMS cannot approve TN 05-011 without absolute assurance that providers are retaining 100% of Medicaid payments.

What is an indigent care agreement?

Texas has available public funds that are dedicated to healthcare needs in the form of ad valorem tax revenues assessed at the local levels by Counties and Hospital Districts ("Local Taxing Entities"). . . . Due to reductions in Medicaid spending and a growing Medicaid and uninsured population ("indigent"), there is a growing gap between the costs hospitals incur for treating indigent patients and the reimbursement they receive. In light of the growing gap between the cost of care and reimbursement, the Local Taxing Entity in certain Texas communities joined with private safety-net hospitals to design a collaborative program to more fully fund the Medicaid program under current law and ensure the availability of quality healthcare services for the indigent population. An indigent care agreement is the agreement between the Local Taxing Entity and a group of local private hospitals ("Affiliated Hospitals") to develop a plan for the Affiliated Hospitals to alleviate the Local Taxing Entity's tax burden by providing care to the indigent, thereby allowing the Local Taxing Entity to utilize its ad valorem tax revenue to fund the Medicaid program. Examples of the types of indigent care services the Affiliated Hospitals may provide include inpatient and outpatient hospital services, specialty physician services, pharmaceutical services, kidney dialysis, dentistry, nursing hotline services, air ambulance services, emergency and on-call physician services, and ophthalmology. The provision of these indigent services by the Affiliated Hospitals directly to indigent patients will alleviate a portion of the Local Taxing Entity's expense of providing indigent care. The Local Taxing Entity will utilize part of its ad valorem tax revenue dedicated to healthcare needs to fund the Medicaid program, either by making an intergovernmental

> **transfer of the tax revenue to the State as the non-Federal share of the Medicaid supplemental payment program or by making a supplemental payment directly to the Affiliated Hospitals based on each hospital's available Medicaid UPL room.**
>
> Does this agreement require any transfer of funds between the hospital and the hospital district\local government? If so please explain the requirement and describe both the amount and timing of the transfer.
>
> **The indigent care agreements do not require any transfer of funds between the Affiliated Hospitals and the Local Taxing Entity.**

Tex. Ex. 5, at 4-5 (State responses in bold in original); *see also* Int. Ex. 4. CMS approved both State plan amendments in 2006 after receiving responses to its requests for information. Int. Ex. 6; Tex. Ex. 4.

On April 12, 2007, CMS began a financial management review of the State's operation of the private hospital UPL program under the two State plan amendments. CMS Ex. 1. CMS expressed concern that preliminary documentation from the State and other sources appeared "to indicate that private hospitals may be satisfying certain fiscal obligations that are otherwise those of local Governments" and advised that "[s]uch a circumstance would be inconsistent with the bona fide provider-related donation requirements[.]" *Id.* at 1. After its review, CMS issued three deferral letters, two on October 5, 2007, and one on January 28, 2008. *Id.*; Tex. Ex. 7.

The State responded that the private hospitals did not assume any legal obligations of the County HDs and that the charity care provided by the private hospitals benefitted patients rather than satisfying obligations of the County HDs. Tex. Ex. 8. The State explained that, in areas with County HDs, a model was typically used in which charity care might be "provided through a nonprofit or public healthcare organization . . . , often (though not always) with their own hospital facilities," where the County HDs "historically had contracts with physician groups and other vendors of healthcare services to serve indigent patients." *Id.* at 5. Nevertheless, said the State, no contractual obligations of the County HDs were assumed by the AHs because, "[t]o the extent that the local government entities had preexisting contractual obligations to third parties, such as physician groups, those obligations were terminated." *Id.* at 6.

In a letter to CMS dated May 1, 2008, the State decided not to contest one of the deferrals, asserted that the expenditures covered by the other two deferrals were allowable, and provided a document entitled "Prospective Conditions of Participation" (Prospective CoPs).[6] Tex. Ex. 9. Under the Prospective CoPs, AHs receiving supplemental payments "may not be assigned the indigent care contractual or statutory obligations" of a County HD making IGTs. *Id.* at 4. Such an AH may, however, "provide indigent care by entering into its own arrangements (contractual or otherwise) with health care providers that had previously provided indigent care services to the transferring governmental entity." *Id.* Furthermore, the amount of supplemental payments to AHs must not be linked to ("conditioned on or measured by") the indigent care provided by the AHs (but an AH may consider what it expects to receive in supplemental payments in deciding whether to participate in an indigent care agreement and a governmental entity may consider "historical experience" in deciding what supplemental payments to make). *Id.* The program, under the Prospective CoPs, "must not include any cash or in kind transfers" from AHs to County HDs that are supplying the IGTs to fund supplemental UPL payments (other than unrelated, arm's-length transactions). *Id.* at 5.

During May 2008, CMS officials exchanged e-mails with State representatives about releasing the remaining deferrals. Tex. Ex. 10. CMS requested confirmation that, going forward, UPL supplemental payments would be funded exclusively by funds the local governmental entities derived from taxes or others sources not derived directly or indirectly from transfers from the private hospitals (AHs). *Id.* at 1. Counsel responded for the State as follows:

> The State is reluctant to represent that the funding will be exclusively from local tax dollars because the government entities do have other revenue sources and IGTs will typically be made from general revenue funds that obtain revenue from sources other than taxes. I believe the underscored wording provides CMS the protection it wants – that **the private hospitals are not in any way the source of the transferred funds.**

Id. (emphasis added).

CMS ultimately released the remaining deferrals and the State then re-initiated the program. Int. Ex. 18.

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[6] The Intervenors describe Prospective CoPs as "jointly developed" among the State, local governments, private providers and CMS, and "approved by CMS." Int. Br. at 11; *see also* Int. Ex. 18, at 2 (State letter to providers asserting that CMS approved the revised CoPs). CMS points out, however, that no documentation shows that CMS actually approved the Prospective CoPs. CMS Br. at 7 (and record citations therein).

C. State waiver – relevant provisions for the supplemental payments

From December 12, 2011, through September 30, 2016, Texas operated its Medicaid program under a waiver demonstration project called the Texas Healthcare Transformation and Quality Improvement Program approved by CMS under section 1115(a) of the Act. CMS Ex. 4. Section 1115(a) allows the Secretary to approve "any experimental, pilot, or demonstration project which . . . is likely to assist in promoting the objectives of" the Medicaid program and to waive compliance with certain specific requirements "to the extent and for the period . . . necessary to enable such State or States to carry out such project . . . ." Each section 1115(a) demonstration project is subject to specific terms and conditions. The Texas waiver planned to expand managed care statewide and "to operate a funding pool, supported by managed care savings and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to participating hospitals that implement and operate delivery system reforms." CMS Ex. 4, at 3.

The waiver provided for a pool to fund payments to "help defray uncompensated costs of care provided to Medicaid or Demonstration eligibles or to individuals who have no source of third party coverage, for the services provided by hospitals or other providers[.]" *Id.* at 49. Payments from this pool were to supplement Medicaid payments for services provided but were not to exceed actual costs even combined with other supplemental payments.[7] *Id.* Among other requirements, to be eligible to receive supplemental payments from the uncompensated care (UC) pool, private providers needed to "have an executed indigent care affiliation agreement on file" with the State Medicaid agency. *Id.* at 50. The UC payments replaced the UPL payments previously made under the State plan.

The waiver plan provided that the "non-Federal share of pool payments to providers may be funded by state general revenue funds, transfers from units of local government, and certified public expenditures that are compliant with section 1903(w) of the Act" and required that any payments funded by IGTs "remain with the provider, and may not be transferred back to any unit of government." *Id.* at 49. The waiver plan also contained, inter alia, the following certification:

[7] We do not discuss waiver provisions relating to transition payments because the transition period is not at issue. A second funding pool, called the "Delivery System Reform Incentive Payment Pool," was to be "based in Regional Healthcare Partnerships" between public and private entities to develop specific delivery initiatives to meet local needs. CMS Ex. 4, at 54. We do not discuss this pool further as Texas indicated that only the uncompensated care (UC) pool funded the supplemental payments at issue here. Tex. Br. at 8.

> **55. Sources of Non-Federal Share.** The State certifies that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
>
> a. CMS may review, at any time, the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. . . .

Id. at 65. The waiver plan further noted that Texas had to submit for "CMS approval a funding and reimbursement protocol that will establish rules and guidelines for the State to claim FFP for UC Payments" before any such payments would be eligible for federal reimbursement. *Id.* at 51.

CMS reports that Texas submitted a document entitled "Intergovernmental Transfers (IGT) Guidelines & Selected Examples," in association with its waiver plan. CMS Br. at 9 (citing CMS Ex. 6 (Guidelines)). Texas's Guidelines purported to provide "high level guidance to entities seeking to generate a state match" through IGT for the waiver program, including the UC pool. CMS Ex. 6, at 1. The Guidelines explained that the funds to be transferred by IGT must be "public funds, not private funds" and must not be "impermissible provider-related donations." *Id.* Texas then defined a provider-related donation in its Guidelines as:

> a. a voluntary donation from a non-governmentally operated health care provider or entity related to a private health care provider;
>
> b. in cash or in kind;
>
> c. made to a governmental entity, whether or not that entity provides for an IGT; and
>
> d. is directly or indirectly related to a Medicaid payment or other payment to providers.

Id. at 1-2. Finally, the Guidelines explained when Texas understood an IGT to violate provider-donation restrictions:

> Federal regulations prohibit private health care providers from making donations directly to [the Texas State Medicaid agency] or indirectly through another government agency to [the Texas State Medicaid agency]. However, federal law recognizes that private providers can undertake to support community activities. Local governmental entities may take that support into account when determining to make an IGT that will be used to fund Medicaid payments to those providers. It is vital that, in such a situation, the existence or amount of an IGT is not contingent upon the existence of such community support or the amount of the community support.

Id. at 2.[8]

D. CMS's 2014 financial management review and resulting deferral and disallowance

In May 2014, CMS undertook another financial management review to determine, among other things, whether the source of non-federal funds for payments under the waiver program was allowable. Tex. Ex. 12, at 1. By letter dated September 30, 2014, CMS notified the State that the review had been completed. Tex. Ex. 13.

As a result of the review, CMS announced that it was deferring $74,891,536 for UC payments made in the quarter that ended June 30, 2014. The letter stated:

> CMS has questions regarding the source of the non-federal share of these expenditures. In particular, CMS would like to explore further our understanding of the financing mechanism being utilized and its intersection with the recent guidance issued in State Medicaid Director Letter #14-004 on May 9, 2014. It appears that the intergovernmental transfer (IGT) may be derived from funds that the government entity previously would have spent on providing the services that are now being provided/funded by the private entity and or direct payments made to the governmental entity from private entities.

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[8] CMS points out (and Texas does not dispute) that, despite their title, the Guidelines do not contain any examples, but that a draft version of the same document did contain examples of impermissible funding arrangements, including one that CMS says "appears to describe the funding model at issue in this case." CMS Br. at 9 (citing CMS Ex. 5). That example assumes a public hospital has a $100 contract for physicians to staff the hospital which it then terminates, and that a non-profit entity takes over the contract (noting that the non-profit entity does not pay public hospital employees because the physicians are contractors, not employees). CMS Ex. 5, at 2. The public hospital then makes an IGT of $60 "on behalf of the hospitals composing" the non-profit entity, with "the purpose of providing the state match necessary for the private hospitals to draw a federal payment from the UC Pool to offset some/all of their allowable uncompensated care costs." *Id.* CMS did not comment on, and Texas did not explain, why this example was not included in the final submitted Guidelines.

Id. at 1.

Negotiations ensued between the parties. CMS released the deferral while expressly noting that the release did not "constitute CMS's acceptance of the financing arrangements." Tex. Ex. 14. CMS also stated that, recognizing the recent "clarifying guidance" in SMDL 14-004, CMS would work with Texas to ensure understanding and make any "necessary adjustments" going forward, at least by December 2014. *Id.* at 1.

After further meetings, calls, and correspondence, CMS issued this disallowance on September 1, 2016. Tex. Ex. 17. Texas sought reconsideration, which CMS denied. Tex. Exs. 18, 19. This appeal then followed.

III. Burden of Proof

In decisions reviewing disputed disallowances, the Board "has consistently held that a state has the burden to document the allowability and allocability of its claims for FFP." *Pa Dept. of Human Servs.*, DAB No. 2835, at 5 (2017) (quoting *N.J. Dept. of Human Servs.*, DAB No. 2328, at 4-5 (2010)) (internal quotation marks omitted). For states, this burden is based on the requirement in federal cost principles that costs claimed must "[b]e adequately documented" (45 C.F.R. § 75.403(g)) and on grant administration requirements, including the requirement that grantees maintain accounting records supported by source documentation. *N.J. Dept. of Health*, DAB No. 2497, at 4 (2013).[9]

IV. Analysis

A. The AHs made indirect provider donations that benefitted the County HDs.

The record establishes that the AHs did not provide the indigent care in these arrangements through services in or by the private hospitals themselves but instead funded the provider-related entities (DCICC and TCICC) which, in turn, used the funding to contract for physicians to provide services in the County HD public hospitals. Indeed,

[9] We note that, in its briefing, the State repeatedly misunderstands the applicable burden of proof. *See, e.g.*, Tex. Br. at 12, 17-18. From its earliest decisions, the Board has emphasized that a grantee (which the State is here) always has the burden of documenting that it is entitled to claim the disputed funds in compliance with federal requirements. *See, e.g., Nat'l Urban League*, DAB No. 289, at 2 (1982). We therefore reject suggestions that the State somehow shifted the burden of proving whether the payments here were based on impermissible provider donations to CMS. Apparently, the State mistook its burden of proof of allowability of all claimed funds for a mere requirement to present a prima facie case for allowability. *See* Tex. Br. at 14 n.59 (citing *Hillman Rehab. Ctr.*, DAB No. 1663 (1998) ("A prima facie case does not amount to an irrebuttable presumption, but rather to evidence sufficient to support a decision in a party's favor, absent contrary evidence.")).

it is undisputed that the physician services contracts were often with the same health-care providers with which the County HDs had previously contracted to staff their hospitals, although the prior contracts were terminated rather than transferred to the entities formed by the AHs.

The statutory language sets a default that donations by providers are not allowed as a source of non-federal matching funds while making an exception for bona fide donations that have no relationship, direct or indirect, to Medicaid payments to donating providers. Act § 1903(w). The Act confers considerable discretion on the Secretary to determine the boundaries of what constitutes a bona fide donation. Act § 1903(w)(2)(B). Given that default, the first question we must address is whether the arrangements between the AHs, related entities, and County HDs amount to private donations to the local government entities. We conclude that they do.

In the first place, we note that passing the funding through the related entities does not make any relevant difference to the analysis, since donations may be direct or indirect. The essential core of the arrangement is that the **private hospitals pay to staff public hospitals**. Before entering into these arrangements, the County HDs paid to staff their own hospitals. By providing the staffing for those hospitals, the AHs provide in-kind replacement for the costs of staffing otherwise incurred by the County HDs just as surely as if they gave the County HDs money with which to pay for the staffing contracts. The contracts by the AHs to provide the physician services in the public hospitals therefore amount to in-kind donations to the County HDs operating the public hospitals.

The State and Intervenors nevertheless deny that the AHs were making donations to the County HDs. They base this denial on several arguments: (1) that the recipients of the physician services were the indigent patients not County HDs; (2) that the County HDs had no legal or contractual obligation to provide these physician services, and so the AHs were not relieving the County HDs of legal or contractual obligations by undertaking them and therefore could not be found to be making a provider donation; and (3) that the State had no notice that CMS interpreted provider donations so broadly as to encompass any indirect transfer of value in the form of the provision of services. Although there is some overlap among these positions, we address each argument in turn.

First, as to the question of benefit from the physician contracts, while it is certainly true that physicians treat patients, the contracts to provide physicians to staff the public hospitals benefitted the County HDs that would otherwise need to ensure physician coverage. The State argues that Texas law merely provides that County HDs "may appoint, contract for, or employ physicians," but that such authority is "permissive, not mandatory" and "only as necessary for the district to fulfill the district's statutory mandate to provide medical and dental care for the indigent and needy residents of the

district." Tex. Br. at 22 (quoting Tex. Health & Safety Code §§ 281.0282(a), (d) and 281.0286(a), (d)) (internal quotation marks omitted). Indeed, Texas denies that hospitals in its State are required to employ physicians at all. Tex. Reply at 3-5. Texas does not deny, however, that hospitals must have medical staffs, nor does it deny that the County HDs had medical staffs through contractual arrangements until the AHs undertook to provide the staff to the County HDs' hospitals by making similar contractual arrangements. In short, the AHs did not merely provide physician services to AH patients; instead, they financed physician staffing so that the public hospitals could serve patients of the public hospitals at those hospitals.

Perhaps most telling as to the receipt of benefits by the County HDs is the evidence presented by CMS that Tarrant County HD reported in its financial statements that it "recognizes revenue from contributed services equal to the difference in the value of the services provided by TCICC and the program funding provided by the District" and that the "[c]ontributed services revenue" amounted to about $11.3 million in 2015 and $8.2 million in 2016. CMS Ex. 13, at 49; *see also* CMS Br. at 24-25 (and additional record citations therein). The financial statement also makes clear that, prior to the contributions by TCICC, "the medical direction and indigent care services were funded by the District," and the County HD still maintained a "standby agreement with physicians participating in this program under which the District would assume the payment obligations of TCICC." CMS Ex. 13, at 49.[10]

We conclude that the County HDs clearly benefit financially from having the AH-related entities take over the costs of medical staffing in public hospitals which they previously funded or otherwise would have to fund themselves.

We turn next to the argument that the County HDs had no binding legal or contractual obligation to provide physician services and that this contention precludes finding a donation. The Intervenors characterize SMDL 14-004 as a "complete reversal" that "eviscerated longstanding policy in declaring there was no need to conduct the statutorily defined test to determine whether a provider-related donation existed." Int. Br. at 14. According to the Intervenors, since 2006 CMS had a test in effect to find a donation only where the government entity had a "legal or contractual obligation" to provide the service in question, but that, in SMDL 14-004, CMS created a "programmatic responsibility" test amounting to a "universal prohibition on any private entity providing charity care that a governmental entity had ever furnished – regardless of whether the governmental entity

[10] Although CMS does not point to any financial statement in the record for the Dallas County HD, the parties do not identify any relevant difference in the situations of the two County HDs at issue. The State asserts that recognizing the value of contributed services does not make those services a donation, without explaining why that would not be a reasonable conclusion, but does not suggest that the Dallas County HD does not also recognize value from the contributed services. *See* Tex. Reply at 7-8.

discontinued the service for budgetary reasons, only performed the services on a one-time basis (such as health screenings or free mammograms), or discontinued the services on any grounds . . . ." *Id.* at 14-15. The State makes a similar claim that a provider donation cannot exist if the AHs merely assume a financial responsibility of the County HDs absent a showing that the financial obligation is one that the County HD "is *legally required to fulfill.*" Tex. Br. at 21 (italics in original).

Despite these blanket assertions, neither the State nor the Intervenors has demonstrated that CMS ever set out a policy narrowly limiting recognition of provider donations to government entities to situations in which the in-kind goods or services provided were ones which the governmental entity had a legal obligation to provide by statute or contract. Certainly, it is logical that a donation exists when a private party relieves a governmental entity of a legally-binding obligation, but it does not follow that a donation can be found to exist only under such circumstances. On the other side, the discussion and examples set out in SMDL 14-004 do not suggest the unbounded understanding of provider donations painted by the Intervenors. SMDL 14-004 does not state that a donation occurs any time a private entity offers a service that a governmental entity has ever at any time provided. The examples involve private parties providing below-market use of space or free (to the governmental entity) services that directly replace expenditures previously incurred by the governmental entity. Int. Ex. 1, at 3-4.

The arrangements at issue here do not remotely resemble a private hospital offering health screenings or mammograms to the public when a governmental hospital once offered a similar service but ceased to do so. Nor do we agree with the State's characterization of CMS's treatment of the term "donation" as applying to every "incidental benefit" to a governmental entity with the risk of deterring any service to the community that might result in fewer demands on the government for services. Tex. Br. at 23. The general meaning of "donation" is the provision of something of value to another for the latter's benefit. *See, e.g., Black's Law Dictionary* (10th ed. 2014) (defining "donation" as, inter alia, "[t]he act of giving something, esp. money, to help a person or an organization"). For an entity to take over an expense that another organization previously incurred and would incur in the absence of that assistance can reasonably be characterized as a donation to help or benefit the organization receiving the relief. We have not found (and neither the State nor Intervenors has shown) authority for the proposition that no donation occurs in such circumstances unless a legally-binding statute or contract would oblige the recipient to continue to make the expenditure but for the transfer. We find the arrangements here fit the framework of a donation of in-kind services for the benefit of the County HDs which would otherwise incur the cost of providing the physician services.

Finally, we consider the claim that the State lacked notice that such indirect in-kind transfers to governmental entities might be considered donations. The State implies that CMS created a new interpretation of the meaning of "donation" when CMS stated in its brief that it broadly interprets section 1903(w)(2)(A) "to include donated services and other transfers of value" from health care providers to a governmental entity." Tex. Reply at 2. Texas argues that the phrase "transfers of value" does not appear in the statute or regulations and the only basis for considering "donated services" as within that category is that CMS suggests it will "know it when it sees it." *Id.* Thus, says the State, CMS has failed to provide "fair warning" or clear explanation of its interpretation of the statute and hence it cannot prevail. *Id.* at 2-3 (quoting *Wisc. Resources Protection Council v. Flambeau Min. Co.*, 727 F.3d 700, 707 (7th Cir. 2013)) (internal quotation marks omitted). This argument simply ignores the sweeping language of the statute itself which specifically defines "provider-related donation" to include "any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly)." Act § 1903(w)(2)(A). It does not require any broad interpretation of this language to recognize that such donations include donated services since those are donations "in kind" within the plain meaning of the statute. Nor is notice of an interpretation required to also recognize that a donation may occur even if the transfer is not directly from a private hospital to government entity but, as here, is passed through a provider-related entity, since the statute expressly includes donations made indirectly.[11] We see no notice problem.

B. The funds County HDs used for IGTs resulted from the provider donations.

As shown in the communications summarized in the background section of this decision, the State repeatedly represented to CMS that the funding for the supplemental payments to the private hospitals was derived from IGTs made by the County HDs from ad valorem tax revenues (or possibly other revenue sources unrelated to the AHs or their related entities). CMS states in its brief, however, that there is now "no dispute that the IGTs were derived" from the TCICC and DCICC funding of the physician services contracts in order that the County HDs had resources freed to make the IGTs to the State. CMS Br. at 25.

In its reply, the State does not directly dispute this statement. Instead, it states that Texas rules require both private and public hospitals to "have a source of public funds as the non-federal share of a payment" and that, in either case, the maximum payments to the private hospitals "will be reduced if sufficient public funds are not transferred to the State as the non-federal share." Tex. Reply at 16 (citing 1 Tex. Admin. Code

[11] The use of the phrase "and other transfers of value" in CMS's brief has no particular legal significance in any event since what is in fact involved here are indirect donations of services.

§ 355.8201(c)(1)(A) and (h)(2)(B)). The State further asserts that it "doesn't matter whether the underlying source of the IGT is tax revenue, hospital patient revenue, provider fees, or another permissible source," but that "any hospital . . . that lacks sufficient IGT to support its maximum payment amount will receive a reduced payment under the rules." *Id.*

It may not matter to how Texas applies its administrative rules, but it does matter to whether the IGTs are protected under section 1903(w)(6) of the Act. That section protects state sources of non-federal share that are derived either from certified public expenditures (such as may be made by public hospitals) or from IGTs "derived from State or local taxes" unless the IGTs are derived "from donations or taxes that would not otherwise be recognized as the non-Federal share." Act § 1903(w)(6)(A). The State has failed to show that the IGTs here are derived from local tax revenues and not from donations by the AHs.

C. The provider donations were part of a "hold harmless" practice within the meaning of the statute and regulations.

The remaining essential question before us is whether the provider donations from which the IGTs were derived were impermissible. The donations are permissible under 42 C.F.R. § 433.54(b) only if they are determined to have "no direct or indirect relationship to Medicaid payments" in that they are not returned to the providers who make the donations under a "hold harmless practice." Such a practice exists under the regulations if any one of three tests in section 433.54(c), which we summarize below, is met:

(1) The amount of payment to the provider is "positively correlated" to the donation – meaning any "positive relationship between these variables, even if not consistent over time," i.e., the positive correlation test.
(2) Any part of the payment to the provider "varies based only on the amount of the donation," including being "conditional on receipt of the donation," i.e., the conditional receipt test.
(3) The governmental entity "directly or indirectly guarantees to return any portion of the donation" to the provider, i.e., the guarantee test.

CMS contends that the operation of Texas's section 1115 waiver program met the guarantee test because the AHs knew, or could reasonably expect, that they would receive back all or most of the funds they paid into the physician services contracts through the supplemental payments funded by the County HD's IGT payments to the State for the benefit of the AHs. CMS Br. at 25-29. CMS points out that private hospitals' eligibility for the UC payments under the waiver is contingent on their having an affiliation agreement and a source of public funding. *Id.* at 27 (citing CMS Ex. 8, at 3-

4 (1 Tex. Admin. Code § 355.8201(c))). The UC payment amount then "will be determined based on the amount of the funds transferred by the affiliated governmental entity" on the basis that the hospital will get the "full payment amount calculated for that payment" only if "the government entity transfers the maximum amount" set out based on the regulation. CMS Ex. 8, at 16 (quoting 1 Tex. Admin. Code § 355.8201(h)). CMS proffers evidence that those AHs that contribute greater amounts to the TCICC or DCICC are allocated more of the respective County HD's IGTs and correspondingly receive larger supplemental UC payments. CMS Br. at 27-28 (and record citations therein). CMS also stresses that the Intervenor AHs have reported "net revenues from their participation in the 1115 Waiver program during their associated fiscal years." *Id.* at 28 (and record citations therein). Indeed, CMS asserts that both the Baylor and Tenet systems reported receiving amounts in supplemental payments that exceeded their contributions under their affiliation agreements. *Id.* at 28-29 (citing CMS Ex. 27 and CMS Ex. 54, at 3).

The State and Intervenors do not deny the factual allegations as to the financial arrangements but strongly deny that these arrangements amount to a guarantee that the AHs will be held harmless for their expenditures in the public-private indigent care partnerships. Tex. Br. at 26-27. Indeed, the State points to certifications required from the AHs and County HDs containing denials that any "such guarantee exists." *Id.* at 27 (citing Tex. Exs. 20 and 21 (sample certifications from an AH and County HD respectively)); *see also* Int. Br. at 11. The Intervenors describe the public-private partnerships as voluntary collaborations operating on "two separate, but parallel, tracks," with the County HDs having "sole discretion" over whether they "want[ ] to use any tax revenue for the Medicaid program," and, "independently, the private hospitals hav[ing] the sole discretion over the amount of charity care they provide." Int. Br. at 19 (footnote omitted[12]).

First, we note that the regulation speaks of a hold harmless "practice" so our focus is on what the practice is among the participants in these arrangements, not merely on paper assurances or guarantees. For this reason, too, mere paper certificates asserting that no guarantee or quid pro quo is intended are insufficient to establish that the AHs are not, in practice, held harmless for any outlay in the form of the in-kind donation of physician services to the County HDs.[13] While the actions of the AHs and County HDs may be

[12] The footnote, however, cites the Prospective CoPs, which state that hospitals "may consider the amount of supplemental payments when determining the level of charity care" and that County HDs "may consider historical charity care provided by private hospitals" when determining the amount of IGTs. Int. Br. at 19 n.49 (citing Int. Ex. 14, at 5).

[13] As SMDL 14-004 puts it, "[r]egardless of the expressed *intent* of providers and governmental entities, when there is an effective return of some, or all, of the donation to the private provider through Medicaid supplemental payments, a hold harmless arrangement exists." Int. Ex. 1, at 4.

voluntary and independent, in the sense that neither has a legal obligation to participate, it is evident that in practice the County HDs have not and would not make future IGTs on behalf of the AHs if the AHs ceased to pay for the physician services in the County HD facilities, whether directly or through AH-related entities like TCICC and DCICC. The practice is therefore one of mutual dependence.

Second, we find compelling the evidence CMS presents of the operation of the arrangements at issue here as one in which the recent supplemental payments are legally tied to the County HDs making IGTs on behalf of the AHs and the IGTs are assigned to the AHs in proportion to the size of the donations by the AHs. Despite extensive arguments denying that the County HDs were obliged to incur the costs of physician services if the AHs had not assumed them, neither the State nor the Intervenors provide any evidence contradicting the showing by CMS that the County HDs, in practice, ensure that the AHs that provide the financing for the physician services are allocated IGTs sufficient to draw down at least as much in supplemental Medicaid payments as the AHs donate. The State asserts that, even if a private hospital paid "for any or all of the expenses" of a County HD, the County HD would "still have no obligation to transfer public funds to draw down supplemental payments for the private hospital." Tex. Reply at 17. We find this assertion entirely disingenuous in light of the uncontradicted reality that the IGT transfers were in practice dependent on the continued donations.

CMS also argues that it has made clear, ever since 2008, that a hold harmless practice exists in the case of a reasonable expectation of receiving an offsetting government payment. CMS Br. at 26. CMS points to the preamble to the adoption of the final rule defining hold harmless arrangements for provider-related tax purposes. *Id.* (citing 73 Fed. Reg. 9685 (Feb. 22, 2008)). CMS there explained:

> A direct guarantee would be found when a State payment is made available to a taxpayer or a party related to the taxpayer (for example, as a nursing home resident is related to a nursing home), in the **reasonable expectation** that the payment would result in the taxpayer being held harmless for any part of the tax.

73 Fed. Reg. at 9686 (emphasis added). The State points out that this language relates to the regulations regarding the hold harmless test for provider-related taxes and argues that CMS may not, in any case, "amend" a regulation through a preamble to "create law." Texas Reply at 15. CMS responds that, even though the final rule was primarily related to taxes, the regulation explicitly pointed out that it "clarifies the standard for determining the existence of a hold harmless arrangement under the positive correlation test, Medicaid

payment test, and the guarantee test (with conforming changes to parallel provisions concerning hold harmless arrangements with respect to provider-related donations)." CMS Surreply at 13 (quoting 73 Fed. Reg. at 9685). Moreover, as we pointed out in our background discussion, CMS has long treated the hold harmless condition in regard to provider-related taxes and to provider donations as parallel in order to provide "continuity and consistency in the treatment of funding sources[.]" 57 Fed. Reg. at 55,120. To the extent that it was not clear before this issuance that a hold harmless practice would be found when a private provider and a local government arranged for provider donations to trigger supplemental payments effectively reimbursing the donor, the preamble provided clarification of CMS's interpretation of what a guarantee to hold harmless means. We do not agree with the State that providing public notice of this interpretation amounted to creating new law.

Certainly, all the participants here based their actions on reasonable expectations that the other parties would continue to respond in kind. In fact, Texas has itself characterized the relationship as depending not on "binding commitments on the part of the participating local governments or private hospitals (so-called 'quid pro quos'), but rather on the basis of legally unenforceable goals and **reasonable expectations** . . . ." CMS Ex. 3, at 4 (March 31, 2008 letter from Texas Medicaid program official to CMS in negotiations seeking release of deferrals) (emphasis added); *see also* Tex. Ex. 8, at 2 ("program is driven by expectations but not by binding requirements on any participant"). Even if we did not apply a "reasonable expectations" standard, however, the undisputed and consistent practices of the participants tying the IGT amounts to the AH donations would suffice under these circumstances to establish that the AHs were held harmless in making their donations to the County HDs.

We conclude that the net effect of the arrangements under review amounted to impermissible provider donations, making the resulting supplemental payments to the AHs unallowable. To permit the State's position to prevail here would make the bona fide provider donation provisions virtually meaningless since a state could always arrange to process provider payments through local governments' IGTs if, in practice, the providers could confidently expect return of all the money or more in the form of supplemental Medicaid payments in which their own contributions provided the "state" share with only federal dollars drawn in from outside this loop.

D. Other arguments of the State and the Intervenors do not alter our conclusion that the donations were not bona fide and the payments to the AHs were unallowable.

1. *CMS is not precluded from taking this disallowance based on its prior interactions with the State.*

As mentioned earlier, the State and Intervenors portray CMS as suddenly and inexplicably reversing a decade of approval of the same practices which it now disallows, despite having received complete information from the State throughout. A careful review of the communications of record between the State and CMS over the years does not support this portrayal.

The Intervenors present a chart of nine communications which they assert demonstrate CMS's consistent approval of "this basic collaborative structure." Int. Br. at 4-5. The vagueness of this description is echoed by the mostly irrelevant excerpts presented in this chart. Three excerpts quote from materials submitted by officials in other states (Louisiana and Nevada in 2010, 2011, and 2014) to CMS seeking approval for their own state plan amendments. The excerpted quotations from the state officials represent that private hospitals will increase their own provision of services to the needy which would mean the government would have more public funds available to support Medicaid services. None of the quotations indicate that the private hospitals will fund services to be provided in or by the government's facilities or that the governments' support of Medicaid services would be in the form of supplemental payments directed to those hospitals that contribute to funding such services.[14]

Four other quotations are taken from letters Texas officials sent to CMS in 2006 and 2008 relating to CMS's expressed concerns about the State's UPL program (which predated the UC program under the section 1115 waiver at issue here). To begin with, the context of CMS's repeated inquiries and requests for further clarification about how the UPL program would operate demonstrates that CMS had serious questions about its permissibility based on the proposed language and sought assurances about what the actual practice would be. In the June 30, 2006 letter, Texas assured CMS that "the

[14] A fourth quotation gives the somewhat misleading impression that a CMS official specifically cited one provision of a Louisiana state plan amendment referring to hospitals qualifying for disproportionate share hospital (DSH) payments by increasing the "provision of inpatient Medicaid and uninsured services by providing services that were previously delivered and terminated or reduced by a state owned and operated facility" in approving the amendment. Int. Br. at 5 (quoting Int. Ex. 29, at 5). The quoted language was not in the approval letter but was one of various requirements for hospitals to qualify for DSH payments contained in the proposed amendment itself. Int. Ex. 29, at 5. The approval letter merely states that CMS's approval action is based "upon the information provided by the State." *Id.* at 1. We have no way to assess the complete information provided by Louisiana to CMS in relation to its state plan amendment.

provision of these indigent services by the [AHs] directly to indigent patients will alleviate a portion of the [County HD's] expense of providing indigent care" and the County HD "will utilize part of its ad valorem tax revenue dedicated to healthcare needs to fund the Medicaid program . . . ." Int. Ex. 5, at 4-5 (quoted at Int. Br. at 5). CMS thereafter approved the State plan amendment. We see nothing in this letter that discloses that the AHs, rather than providing services directly to patients, would fund physician services provided in the County HDs' facilities or that the savings for County HDs would result from the AHs taking over an expenditure of the County HD facilities rather than from a reduction in demand from indigent care because of increased services by the AHs.

The State claims that CMS has conceded that it "knew in 2007 that private hospitals funded the cost of physician services contracts for care at" County HD facilities. Tex. Reply at 19 n.87 (citing CMS Br. at 5). But what CMS stated in its brief is that it discovered this practice as a result of its 2007 financial management review of the UPL program then in effect in Texas. CMS Br. at 5. The result of the review was the issuance of deferral letters which state that information suggested that the AHs "may be satisfying certain fiscal obligations that are otherwise those of local governments" which would be "inconsistent with the bona fide provider-related donation requirements . . . ." CMS Ex. 1, at 1. The three State letters to CMS in 2008 quoted by the Intervenors are responses to CMS's requests for information and attempts by the State to set out "steps" it would take to "resolve the outstanding issues" in the UPL program. Int. Ex. 14, at 1; *see also* Int. Br. at 5 (citing Int. Exs. 13 and 14).

The Intervenors quote a sentence from the State's May 1, 2008 letter (actually from the attached Prospective CoPs) which comes the closest to suggesting that the State might continue the practice discovered in the 2007 financial management review reading: "[A] private hospital that receives UPL supplemental payments may provide indigent care by entering into its own arrangements (contracts or otherwise) with healthcare providers that had previously provided indigent care services to the transferring governmental entity." Int. Br. at 5 (quoting Int. Ex. 14, at 4). The statement does not disclose that the healthcare providers with which the AHs (through TCICC and DCICC) contracted would continue to provide their services to the transferring County HDs rather than being contracted to provide services to the AHs and their own patients. Moreover, the Prospective CoPs go on to assert that the UPL program "must not include cash or in-kind transfers" from the AHs to the County HDs. Int. Ex. 14, at 5. CMS contends that the assurances in the Prospective CoPs, along with the repeated claims by the State that the AHs were merely "providing charity care" that did not "relieve an obligation" of the

County HDs, led CMS to believe that the AHs were to provide care to indigent patients in their own facilities, rather than funding services in the County HD facilities. CMS Br. at 6 (and record citations therein). Moreover, CMS requested and received assurances (from counsel for the State) that none of the funding for the IGTs would come from the provider donations. Tex. Ex. 10, at 1-2. In other words, CMS contends, with support in the record, that when it learned about problematic aspects of the arrangements, including that the AHs funded services in the County HD facilities and that those in-kind donations might be funding the IGTs, CMS took action and did not release the deferred funds until it was reassured that these concerns would not recur prospectively.

In any case, we note that the communications to which the State and the Intervenors point are largely related to the prior UPL program. The State claims that CMS knew that the UC program under the waiver would be "financed using those same funding mechanisms," but the only basis it cites for this claim is a quotation from the waiver terms and conditions stating that "[p]rivate providers must have an executed indigent care affiliation agreement on file" which hardly identifies the specific practices which triggered this disallowance. Tex. Br. at 8 n.33 (quoting Tex. Ex. 11). Even had CMS known that Texas continued to allow AHs to fund physician services to be performed in County HDs after the issuance of the Prospective CoPs and the assurances on which the deferrals were released, we could not find that CMS was notified that the practice would recur under this waiver language. Contrary to claims that the "specificity and volume" of disclosures to CMS "speak for themselves" and that discounting their significance because they predated the waiver is "absurd," we find that the State has not shown that it ever clearly informed CMS that it would operate prospectively under the waiver in the manner that triggered the 2007 review and deferrals. *Contra* Tex. and Int. Joint Sur-surreply Br. (Jt. Sur-surreply) at 2-3.

We conclude that CMS did not knowingly approve the provider donations to County HDs which were used at least in part to fund IGTs, based on the information provided by the State under either the UPL or the later UC waiver programs.

We also point out that, even had CMS knowingly permitted these arrangements at some point, the State has not shown that CMS would thereby be foreclosed permanently from revisiting concerns about the allowability of the supplemental payments under those arrangements. Recognizing the difficulty of asserting estoppel against the federal

government, if it is available at all,[15] the State and Intervenors disclaim any intention to assert that CMS is estopped by "its prior inconsistencies." Jt. Sur-surreply at 4. Indeed, as CMS points out, the terms of the waiver expressly provided that "CMS may review, at any time, the sources of the non-Federal share of funding for the Demonstration." CMS Br. at 34 (quoting CMS Ex. 4, at 65). The express reservation of this review authority reinforces CMS's ongoing concern about how these arrangements would be functioning in practice.

Texas and the Intervenors go on to argue that, while not estopped by prior positions, CMS "is 'estopped' by federal law." Jt. Surreply at 4. But what they then cite is not federal law, but rather two quotations from a preamble in 2007 to a regulation which they acknowledge was vacated. *Id.* (citing 72 Fed. Reg. at 29,762 and 29,799). Moreover, neither quotation supports the claim that CMS in this preamble ever "clearly confirmed the 'legal obligation' standard," as they now assert. *Id.* The first quotation reads: "Local government tax dollars that are not contractually committed for the purpose of indigent care services or any other non-Medicaid activity can be directly transferred by the local government to a State as the non-Federal share of Medicaid payments." 72 Fed. Reg. at 29,762. This statement does not mean that the only criterion for permissible IGTs is that the tax dollars used must not be contractually committed. The context was that CMS was responding to a commenter who argued that "tax revenue that is contractually obligated between a governmental entity and a health care provider to provide indigent care" should be permissible, contrary to the text of the proposed rule. *Id.* And the rest of CMS's response read: "But when a non-governmental provider forgoes payment to which it is contractually entitled from a local government, it would be making a provider donation." *Id.* The quoted language does not provide support for the proposition that CMS ever agreed that a provider donation only occurs when the provider directly assumes a contractual commitment of a local government.

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[15] Both the Board and the courts have questioned whether the federal government can be estopped, "absent, at a minimum, a showing that the traditional requirements for estoppel are present (i.e., a factual misrepresentation by the government, reasonable reliance on the misrepresentation by the party seeking estoppel, and harm or detriment to that party as a result of the reliance) and that the government's employees or agents engaged in 'affirmative misconduct.'" *Ill. Dep't of Children and Family Servs.*, DAB No. 2734, at 8 (2016) (*quoting Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 31 (2011) (citing *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990) and *Pacific Islander Council of Leaders*, DAB No. 2091, at 12 (2007) ("[E]quitable estoppel does not lie against the federal government, if indeed it is available at all, absent at least a showing of affirmative misconduct."))). Moreover, estoppel is an equitable remedy and the Board has repeatedly explained that it "lacks the power to grant equitable relief because it is bound by all applicable laws and regulations." *Kan. Dep't of Admin.*, DAB No. 2845, at 12 (2018) (and cases cited therein). We also summarily reject Texas's suggestion that it incurred these expenditures in reliance on assurances that it would have time to transition to other funding models because the deferral stated that Texas would be expected to "make necessary adjustments by December 2015" or because during discussions CMS stated Texas might have "until September 1, 2017 to make changes to the funding arrangements," if required after discussions. Tex. Br. at 35-36 (citing Tex. Exs. 14 and 15); *see also* Tex. Br. at 9. The State has not denied, however, that the discussions broke down in 2015 and that Texas did not undertake a new funding model or agree to make changes to the funding arrangements, or that CMS instead "proposed identifying a test case to get the issue before an independent arbiter" which led to the disallowance and this appeal. CMS Br. at 38-39 (quoting Tex. Ex. 23, at 4).

The second excerpt was quoted only in part to imply that a provider donation "would result ***if*** a private hospital provides services 'which were otherwise State only or local government only obligations.'" Jt. Sur-surreply at 4 (bold and italics in brief) (quoting 72 Fed. Reg. at 29,799). Even this version nowhere states that provider donations **only** result when services were otherwise government-only obligations. The comments to which this quotation responded had to do with requirements for providers to retain supplemental Medicaid payments (and not return them to the local government, for example). CMS explained that its broad retention requirement was part of its efforts to address the "wide variety of Medicaid financing abuses" which it had "discovered over the years," 72 Fed. Reg. 29,800, and described the relevant example and resulting concerns as follows:

> [H]ealth care providers were required to return a significant portion of a particular Medicaid payment to State or local government either directly upon receipt of such payment or indirectly through a transfer of funds in an amount greater than the non-Federal share to generate such payment. States and local governments would then use these funds to draw additional Federal matching dollars for other Medicaid payments and/or satisfy other non-Medicaid activities. **In addition, health care providers were required to redirect a particular Medicaid payment to other non-Medicaid health programs to satisfy certain non-Medicaid activities, which were otherwise State only or local government only obligations often involving health care services to a non-Medicaid individual.**
>
> These arrangements are inconsistent with statutory construction that the Federal government pays its statutorily identified share of the payments for the provision of the delivery of Medicaid services. The retention of payments provision is intended to clarify the Federal government's authority to identify and correct such abuses.

72 Fed. Reg. at 29,799 (bold added). Nothing in this quotation in context could have led the State to believe that a preexisting governmental obligation was a prerequisite to a determination that the provision of services to a local government entity by a private provider might constitute an impermissible donation. At best, the preamble discussions suggest that CMS would have considered a provider taking over a government contract or being required to spend Medicaid funds to satisfy a government obligation to involve impermissible provider donations. They do not say anything to limit CMS's authority to determine that other situations also involve impermissible provider donations.

Given our analysis, we find no merit in the assertion that CMS has overturned prior law either in this disallowance or in its issuance of SMDL 14-004,[16] and so we do not agree that the disallowance is thereby made arbitrary and capricious, as Texas and the Intervenors argue. Jt. Sur-surreply at 5.[17]

2. *The AHs' support of the related entities may constitute a donation under federal law even if it also meets the charity care requirements under Texas law and provides benefits to the community.*

The State argues that the "charity care" required of nonprofit hospitals under Texas law includes unreimbursed costs of "providing, funding, or otherwise financially supporting health care services provided . . . through other nonprofit or public . . . hospitals," so funding physician services contracts for the public hospitals did constitute charity care. Tex. Br. at 24 (quoting Tex. Health & Safety Code § 311.031(2)(b)). While the use of "charity care" in the various documents submitted to CMS may have been correct under Texas law and not intended to be misleading, CMS could reasonably have understood the phrase to refer to directly serving indigent patients rather than financing services provided through public hospitals. The significance of this misunderstanding, in any case, is only that it may explain why CMS might approve state plans referencing charity care without thereby expressing an opinion that the arrangements now known to have operated between the AHs and County HDs were permissible financing schemes. But, as we have said, even had CMS accepted the arrangements before, it would not be precluded from determining now that they are not in compliance with applicable statutory requirements.

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[16] The State argues at length that CMS cannot "base its disallowance" on SMDL 14-004. Tex. Br. at 28-34. We do not address this argument in detail, because, as our discussion has made clear, we do not see this disallowance as "based" on SMDL 14-004 but rather on the underlying statutory and regulatory provisions as interpreted by CMS in multiple places of which the State had notice, including the SMDL, regulatory history, and direct communications. In any case, we do not agree with the State that SMDL 14-004 is inconsistent with section 433.54(c), constitutes an improperly promulgated legislative rule, or is arbitrary or capricious as applied here. We do agree that SMDL 14-004 is not binding law, and we do not apply it as such. The Board has long held that it will defer to an agency's interpretation of its regulations where there is ambiguity or uncertainty in their terms, so long as the interpretation is reasonable and permissible and so long as the affected party had actual and timely notice of it or, lacking notice, did not actually rely to its detriment on an alternative reasonable interpretation. *N.J. Dep't of Human Servs.*, DAB No. 1773, at 5-6 (2001). SMDL 14-004 constituted one source of notice to the State, not by itself the basis of this disallowance.

[17] We similarly reject the argument that CMS's approval of various Louisiana state plan amendments in 2010, 2014 (mentioned earlier in relation to communications with CMS), and 2016, and of a Nevada state plan amendment in 2012 (also mentioned above), somehow compel acceptance of the arrangements under Texas's section 1115 waiver program. Int. Br. at 12-13, 15-17 (and record citations therein). The record does not contain sufficient detail to permit any conclusion about whether the public-private arrangements involved in the other states' plan amendments result in non-bona fide provider donations for which providers are held harmless, and that issue is not before us in relation to the other states and other time periods. The approval of a state plan amendment does not in itself ensure that CMS may not disallow funds if, in practice, such donations occur. CMS points out that it has in fact disallowed funds in the case of Louisiana under section 1903(w) of the Act. CMS Br. at 35-36 (citing *La. Dep't of Health & Hosp.*, DAB Docket No. A-15-79 (dismissed July 21, 2017 based on settlement agreement)).

The State goes on to conclude that charity care cannot constitute a "donation" to the County HDs because it is a benefit to the individual indigent patients. Providing charity care under Texas law is not inconsistent with having made a donation under federal law. As CMS points out, the physician services may well benefit the indigent patients but the funding of the contract for the physicians to staff the County HD facilities to provide those services may also provide a benefit and value to the County HDs that is properly considered a donation for the reasons we have discussed earlier. CMS Br. at 23-24. Moreover, the same section of Texas law (Tex. Health & Safety Code § 311.031(2)(b)) defines "donations" to include the "unreimbursed costs of providing cash and in kind services and gifts, including facilities, equipment, personnel, and programs, to other nonprofit or public . . . hospitals," so it appears that under Texas law nonprofit hospitals may provide "charity care" in the form of donations to public hospitals, if the services supported go to indigents. Such donations would presumably ultimately benefit those patients, but that does not prevent them from being donations to the public hospitals.

The Intervenors point to the value of indigent residents receiving services in arguing that the public-private partnership arrangement serves an important purpose. Int. Br. at 7 ("[E]xpanded charitable efforts of, and collaborations between, the public and private sectors did result . . . in enormous benefits to local communities struggling to provide care for indigent populations, exacerbated by the State's refusal to expand Medicaid . . . ."). Medicaid is a program of shared responsibility between the states and the federal government. 42 C.F.R. § 430.0 ("program is jointly financed by the Federal and State governments and administered by States"). States are free to provide or arrange for services for their citizens in whatever way they see fit, but, if a state chooses to seek federal participation in an expenditure for medical services, the state must contribute its share to fund the expenditure in accordance with federal law. Neither the disallowance determination nor this decision upholding it implies that it is improper or undesirable for private providers or local government agencies to undertake charitable efforts or collaborations. What section 1903(w) and the implementing regulations disallow is using such arrangements effectively to draw down federal matching funds without any corresponding outlay of state or local government funds by using Medicaid payments to hold the private participants harmless for their contribution.

3. *CMS is not required to show that the AHs are providing precisely the same kind and amount of physician services that the County HDs previously obtained by contract or that the County HDs would obtain if the AHs withdrew from these arrangements.*

The Intervenors dispute that CMS has proven that the County HD contracted for the same services that TCICC/DCICC later provided, or that the County HD would necessarily provide the same contracted services themselves if those entities were to cease supplying physician services in County HD facilities. Int. Reply at 14-15. CMS proffers evidence

tending to show that the County HDs did, in fact, have contingency plans to reacquire physician services contractually but for the TCICC/DCICC arrangements. CMS Surreply at 6-7 (citing CMS Ex. 13, at 49 ("standby agreement with physicians participating in this program"); Int. Ex. 12, at 4; and CMS Ex. 18). CMS also points to various state and federal requirements for hospitals to ensure some medical staffing (although not necessarily as employees). CMS Br. at 22-23; CMS Surreply at 5-6. As we have said, however, we do not see any requirement that the County HDs have a legal or contractual obligation to provide these services (certainly, no requirement to prove they would obtain them through the same contractors) in order to conclude that the services provided in their hospitals were of value and benefit to the County HDs.

4. *The disallowance here is not barred by a 2005 Board decision.*

The State relies on a prior Board decision for the proposition that any finding that a provider is held harmless based on the guarantee test requires proof of an "assurance of payment" which it denies was present in the current situation. Tex. Reply at 13; *Hawaii Dep't of Human Servs., et al.*, DAB No. 1981 (2005), *recon. denied*, DAB Ruling No. 2006-1 (2006). In *Hawaii*, the Board reversed disallowances in multiple states which imposed taxes on nursing homes (in various forms) shortly after passage of the 1991 amendments to section 1903(w) of the Act, and also adopted programs in which grants or tax credit went to private-pay patients in nursing homes.[18] The regulation as in effect at relevant times – section 433.68 – contained a two-prong test to determine if a taxpayer was held harmless, which focused on the tax rate related to revenues and the percentage of taxpayers recouping 75 per cent of their payments. *See* 57 Fed. Reg. at 55,141-55,142; 58 Fed. Reg. 43,156, 43,182 (Aug. 13, 1993). The 1992 version applied the two-prong test only in the absence of an explicit guarantee. 57 Fed. Reg. at 55,143. The Board concluded that CMS did not make the factual showings necessary to apply the "positive correlation" test for holding a taxpayer harmless and that, under both versions of the rule, states were led by preamble language to believe that a program that passed the two-prong test and did not include an explicit guarantee would be permissible. DAB No. 1981, at 32, 36-37. The Board went on to find CMS did not prove an explicit or direct guarantee where the credits or grants to patients did not assure nursing homes would receive any payment (unlike, for example, property tax credit going directly to providers). *Id.* at 38.

[18] The disallowances at issue in *Hawaii* concerned expenditures made by the states in 1992 or 1993 but were not issued until 2001, and the Board decision followed a lengthy process of failed negotiations, discovery, and case development. DAB No. 1981, at 1. The Board's analysis relied heavily on preambles to interim final and final regulations on provider-related taxes published in November 1992 and August 1993. *Id.* at 6-13 (quoting extensively from 57 Fed. Reg. 55,118 (Nov. 24, 1992) and 58 Fed. Reg. 43,156 (Aug. 13, 1993)).

The State argues that the Board in *Hawaii* found that CMS regulations "did not clearly identify that such grants and tax payments amounted to hold harmless arrangements" and then held that, for a payment to be "guaranteed . . . requires a direct or explicit assurance." Tex. Reply at 13. The State then points to the Board's reference to a dictionary definition of "guarantee" as "[s]omething that ensures a particular outcome [or is a] promise or assurance." *Id.* at 14 (quoting DAB No. 1981, at 39 (quoting in turn from Webster's II New College Dictionary (1995))) (internal quotation marks omitted). The State also cites the Board's comment that the term "hold harmless" is "usually used in conjunction with some sort of indemnification that is legally enforceable."[19] *Id.* (quoting DAB No. 1981, at 39).

We find *Hawaii* to be of very limited relevance in analyzing the present case for two reasons: the arrangements involved are factually very different, and the applicable regulations and regulatory history have changed substantially in the years between 1993 and 2015. The Board in *Hawaii* pointed out that CMS did not there argue that the States used Medicaid payments to hold the taxpayers harmless, that the grants or credits were positively correlated to the gap between Medicaid payments and total tax cost, or that any of the tax programs failed to pass the two-prong test. DAB No. 1981, at 3-4. 17, 32-34, 35. Under the regulations then in effect, if a state's tax program passed the two-prong test, the taxpayer would be considered to be held harmless only if the state provided an "explicit" guarantee, as mentioned above. Furthermore, the Board found that the payments which CMS claimed held the nursing homes harmless did not go to the homes themselves (which were the taxpayers) but rather went to non-Medicaid patients so there was no direct recovery by the providers. *Id.* at 4. Furthermore, the Board found nothing that demonstrated that the states were or should have been on notice that these programs were impermissible. *Id.* at 18-23, 27. The current arrangements involve provider donations, not taxes; involve Medicaid supplemental payments directly to the providers; have nothing to do with the two-prong test; include written affiliation agreements laying out mutual planning and expectation rather than mere inferences; and generally differ entirely from the tax programs in *Hawaii*.

Moreover, as CMS points out, CMS amended its hold harmless regulations subsequent to the issuance of the *Hawaii* decision, clarifying its use of some of the terms, as well as issuing additional guidance in SMDL 14-004. CMS Surreply at 11-15. Among other points, the preamble to the final rule issued in 2008 (already discussed more generally earlier in our analysis) explains that a "direct guarantee does not need to be an explicit promise or assurance of payment," but, instead, "the element necessary to constitute a

[19] The Board made that comment in the context of concluding that, "[i]f making a payment available to some taxpayers were sufficient by itself to constitute a hold harmless guarantee, there would be no need for the two-prong test." DAB No. 1981, at 29. The two-prong test has no application in any case in regard to provider donations.

direct guarantee is the provision for payment by State statute, regulation, or policy." 73 Fed. Reg. at 9694. Thus, to the extent the comments that the State quoted from *Hawaii* implied that a guarantee to hold harmless would be found only where indemnification was promised explicitly or legally enforceable, that interpretation was not viable after the regulatory amendments of 2008.

5. *The disallowance notice provided adequate notice of the basis for the disallowance but the amount of the disallowance should be revised.*

The State asks us to reverse the disallowance on the grounds that the disallowance letter does not sufficiently communicate the information required by 42 C.F.R. § 430.42. Tex. Br. at 15-20. Section 430.42 calls for a disallowance letter to include, "as appropriate":

> (1) The date or dates on which the State's claim for FFP was made.
> (2) The time period during which the expenditures in question were made or claimed to have been made.
> (3) The date and amount of any payment or notice of deferral.
> (4) A statement of the amount of FFP claimed, allowed, and disallowed and the manner in which these amounts were computed.
> (5) Findings of fact on which the disallowance determination is based or a reference to other documents previously furnished to the State or included with the notice (such as a report of a financial review or audit) which contain the findings of fact on which the disallowance determination is based.
> (6) Pertinent citations to the law, regulations, guides and instructions supporting the action taken.
> (7) A request that the State make appropriate adjustment in a subsequent expenditure report.
> (8) Notice of the State's right to request reconsideration of the disallowance and the time allowed to make the request.
> (9) A statement indicating that the disallowance letter is the Department's final decision unless the State requests reconsideration under paragraph (b)(2) or (f)(2) of this section.

All of the formal requirements are met by the disallowance letter here. Tex. Ex. 17. The legal basis of the disallowance is clearly identified. The factual details are terse, but the context of the financial management review and ongoing negotiations between the parties supports a conclusion that the information was sufficient to permit the State fairly to respond. Indeed, the factual and legal allegations were well-understood, in light of the State's detailed reconsideration request. Tex. Ex. 18. To the extent the State was less

than clear about CMS's position based on the disallowance determination letter alone, the subsequent proceedings in this matter surely cured any uncertainty. Given the extensive briefing by the parties and the Intervenors, we simply cannot credit any claim that the State was prejudiced by any inability to understand and dispute the underlying facts or the legal positions. We therefore decline the invitation to reverse.

The State raises more substantial concerns, however, about how the disallowance amount was calculated given that the disallowance letter simply states that it was "based on the projected value of in-kind donations" by DCICC and TCICC to the Dallas and Tarrant County HDs. Tex. Ex. 17, at 1. The disallowance letter also contains a footnote table setting out the "estimated quarterly value of various contracts" of DCICC and TCICC which was multiplied by the applicable FFP rate. *Id.* at 4. In seeking reconsideration, the State stated that, even if CMS were correct that the DCICC and TCICC made impermissible provider donations, the disallowance amount should be based on the actual expenditures from the quarter at issue, not estimates or projections. Tex. Ex. 18, at 11. Texas asserts that the actual figures result in a disallowance of $25,276,116. *Id.*

CMS provided Texas with numerous documents and correspondence clarifying how it estimated the imputed revenue to the County HDs from the services provided under contracts financed by the AHs. *See* Tex. Exs. 22-25. CMS has not, however, explained why the disallowance should be calculated using estimated amounts if actual expenditures from the relevant period are available. Furthermore, CMS has not disputed the accuracy of the figures which Texas provided in its reconsideration request.

We therefore accept Texas's figures as the more accurate calculation.

Conclusion

For the reasons explained above, we uphold the disallowance at the reduced amount of $25,276,116.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Leslie A. Sussan
Presiding Board Member

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Texas Health and Human Services Commission
Docket No. A-19-1
Request for Reconsideration of Decision No. 2886
Ruling No. 2020-1
October 2, 2019

RULING ON REQUEST FOR RECONSIDERATION

Texas Health and Human Services Commission (Texas or State) and the Intervenors (collectively Movants) requested the Board reconsider *Texas Health and Human Services Commission*, DAB No. 2886 (2018) (Board Decision 2886). The Centers for Medicare & Medicaid Services (CMS) opposes Movants' request. The Board grants a request for reconsideration only upon a showing of clear error of law or fact. As we discuss below, Movants have not shown any such error.

Movants offer two approaches to challenging the Board's factual findings: first, by contending that the Board overlooked conclusive evidence in the record; and second, by offering new evidence that it claims should alter those findings now. We conclude that the new evidence is inadmissible at this stage because Movants fail to explain why it was not produced during the original proceedings. We further explain below why, even were we to consider that evidence, none of the issues raised by Movants reveal clear errors of fact or law by the Board.

We therefore decline to reconsider Board Decision 2886.

The Board Decision[1]

Board Decision 2886 upheld CMS's determination to disallow $25,276,116 in federal financial participation (FFP) in supplemental Medicaid payments by the State to certain private hospitals (some of which participated in the appeal as Intervenors) for the quarter ending December 31, 2015. The statutory provision at the center of the dispute is section 1903(w) of the Social Security Act (Act), which disallows FFP for state Medicaid

[1] Board Decision 2886 speaks for itself and fully explains the Board's reasoning in upholding the disallowance. The relevant citations to the extensive evidentiary record are also found in the Board's decision. We summarize the key points briefly to provide a context for the discussion below, but nothing explained or omitted in this summary is intended to alter the decision in any way.

payments to the extent of any "revenues received by the State (or by a unit of local government in the State)" from "provider-related donations" other than "bona fide provider-related donations." Act § 1903(w)(1))(A). "Provider-related donation" is defined as "**any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly)** to a State or unit of local government"[2] by a health care provider or related entity. *Id.* § 1903(w)(2)(A) (emphasis added). "Bona fide provider-related donation" is defined as "a provider-related donation that has **no direct or indirect relationship** (as determined by the Secretary [of Health and Human Services]) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary." *Id.* § 1903(w)(2)(B) (emphasis added).[3]

Regulations implementing these provisions require removal from the calculation of FFP of any state Medicaid payments based on provider-related donations received by a state or unit of local government except, as relevant here, "[p]ermissible provider-related donations." 42 C.F.R. § 433.57. The latter term means only "bona fide donations," defined in turn in section 433.54(a) as those that have "no direct or indirect relationship" to Medicaid payments made to the donating provider or any related entity. *Id.* § 433.66(b). Section 433.54(b) explains that no direct or indirect relationship to Medicaid payments exists if such donations "are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice."

Section 433.54(c) (emphasis added) states that 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 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.

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[2] It is undisputed that the counties involved in this case were units of local government for these purposes.

[3] A related provision provides that inter-governmental transfers (IGTs) from units of local government to a state are permissible sources of the state's non-federal share of Medicaid funding so long as the IGTs are not in turn derived from impermissible provider-related donations. Act § 1903(w)(6).

> (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 units of local government involved here are hospital districts of Dallas and Tarrant counties (referred to here simply as counties). The provider-related entities were non-profit corporations (Tarrant County Indigent Care Corporation (TCICC) and Dallas County Indigent Care Corporation (DCICC)) formed by private affiliated hospitals (AHs), including Intervenors. During the period at issue, the AHs received supplemental Medicaid payments from the State if they participated in affiliation agreements with the counties. The agreements provided for the AHs to provide indigent care, for the counties to make IGTs to fund the state share of the supplemental Medicaid payments, and for the AHs to indemnify the counties in the event CMS denied FFP related to the supplemental payments.

In practice, the AHs, through their related entities, rather than provide indigent care themselves, funded physician coverage contracts for care to be provided in the counties' public hospitals. The counties previously contracted for the same services, recognized revenue from the savings that resulted from the AHs paying for these service contracts, and maintained standby agreements to return to paying directly if the AHs failed to fund the contracts. The Board found that these arrangements resulted in indirect in-kind provider-related donations to the counties. Board Decision 2886, at 18. Moreover, the donations freed the funds the counties used to make IGTs to draw down the supplemental funding for the participating AHs.[4] *Id.* at 21.

The Board then considered whether the State had demonstrated that the provider-related donations were bona fide, i.e., had no direct or indirect relationship to the supplemental Medicaid payments to the AHs. The existence of a relationship was apparent under the regulatory tests for a "hold harmless practice." The Board found that the payments to the AHs in practice were indeed positively correlated in amount to their funding of the contracts for physician services coverage in the public hospital. Board Decision 2886, at 22-25. While neither AHs nor counties were legally bound to continue participating or

[4] The Board rejected the argument that CMS had to show the counties had a legal obligation to fund the physician coverage contracts absent the AHs' funding and found it sufficient that the counties had undertaken to use the contracts to provide services in the public hospitals before the arrangements at issue and had in place plans to resume the contracts in the absence of the AHs' funding. Board Decision 2886, at 19-20.

guaranteed that the arrangements would continue, the AHs' access to corresponding amounts of supplemental payments would clearly no longer be available if they did not continue participating. *Id.* at 24-25. The resulting reasonable expectations of mutual dependence on these funding arrangements amounted to sufficient guarantee of returns of the funds expended by the AHs to amount to a hold harmless practice. *Id.* Therefore, the Board concluded, the IGTs were funded by impermissible provider-related donations and the State was not entitled to FFP in the resulting supplemental payments to the AHs. *Id.* at 25.

The Board also rejected claims that CMS was aware of and affirmatively approved the practices at issue based on various communications between the State and CMS over the course of both the current supplemental funding program through a section 1115 waiver program and prior arrangements under the upper payment limit (UPL) program. *Id.* at 26-31. CMS conducted a financial management review of the prior program in 2007, became aware of the problematic aspects of the arrangements in practice despite earlier assurances, deferred payment of FFP, and finally released the deferred funds based on an understanding that the State would not continue those aspects going forward. Even had CMS been aware of the continuation of the practice of AHs funding physician contracts for services provided in and for the county hospitals, which the State failed to show, the Board noted that CMS would not be precluded from ultimately taking this disallowance. The State had ample notice of CMS's concerns and of CMS's reasonable interpretation of the applicable law.

Standard for Reconsideration

The Board will grant a request to reconsider its decision only if the request shows that the decision is based on a "clear error of fact or law." 45 C.F.R. § 16.13. "Reconsideration of a decision is not a routine step" in the Board's adjudication process, but provides an opportunity to identify a clear error so that the Board can make any needed correction. *N.H. Dep't of Health & Human Servs.*, DAB Ruling No. 2012-2, at 7 (2011). The Board has made clear that "arguments, representations, and evidence that an appellant could have submitted with its appeal (but did not) are not considered allegations of errors of fact or law justifying reconsideration of a decision." *Econ. Opportunity Comm'n of Nassau Cnty., Inc.*, DAB Ruling No. 2017-1, at 1 (2017) (EOC Ruling). The Board will therefore "not reconsider a decision 'to address an issue that could have been raised before, but was not, or to receive additional evidence that could have been presented to the Board before it issued its decision, but was not.'" *Ill. Dep't of Healthcare & Family Servs.*, DAB Ruling No. 2019-1, at 1 (2019) (Illinois Ruling) (quoting *Alaska Dep't of Health & Soc. Servs.*, DAB Ruling No. 2008-1, at 4 (2007) (Alaska Ruling)). Parties are advised to

submit appeal files during the appeal process with all documents they consider important to resolving the issues in the case and are expected to explain why any belated material could not have been included in timely submissions. *See* 45 C.F.R. § 16.8(a); Illinois Ruling at 1 (rejecting evidentiary submissions at reconsideration stage as "not the type of newly discovered or previously unavailable documentation that might justify reconsideration").

Analysis

1. Movants' new exhibits are not admissible on reconsideration.

As a preliminary matter, we note that Movants submitted seven exhibits (denominated Reconsideration Exhibits A through G) for the first time with their Joint Motion. CMS objects to the consideration of these exhibits because Movants did not explain their failure to proffer them during the many opportunities provided in the original case that resulted in Board Decision 2886. CMS Response to Joint Motion at 2-3. CMS also notes that, in any case, none of the new exhibits demonstrate any clear error. *Id*. at 3.

Consistent with the limited purpose of reconsideration to alert the Board to a clear error, the Board has long refused on reconsideration to accept new evidentiary submissions that could have been presented in the original appeal. Alaska Ruling at 4; EOC Ruling at 1; *Peoples Involvement Corp.*, DAB Ruling No. 2005-2, at 2 (2005) (A "motion for reconsideration is far too belated a context in which to undertake to present [additional] documentation" where the grantee "made no claim that this documentation was not available to it earlier in this process."). We therefore consider first whether Movants explained why these exhibits could not have been presented to the Board before the decision was issued.

We find no basis to conclude that the exhibits – all of them documents which predate the original appeal in this matter – could not have been presented to the Board in a timely fashion. Movants do not explain the exhibits' provenance. Movants do not suggest they lacked prior access to the exhibits (mostly emails between State and CMS staff dating from 2008-2016). Moreover, the issues as to which these late exhibits are proffered were plainly in dispute during the original appeal.

The closest Movants come to an explanation of the untimely submissions is the statement that they "did not anticipate CMS and the Board would disavow CMS's documented approval of a public/private collaborative that contemplated the provision of indigent care" by physicians of the AHs' related entities and the "provision of staff and physical

plant necessary to treat patients at public hospitals." Joint Motion at 3. If this vague statement is intended to suggest that Movants did not get adequate notice that CMS denied having approved the arrangements that took place during the disallowance period, it is false. The State spent years attempting to allay the concerns repeatedly raised by CMS about the effect of provider donations of contracted physician services freeing funds used by counties to provide indigent care in public hospitals which were then used to draw down Medicaid supplemental payments for the private hospitals. The many rounds of briefing before the Board and multiple submissions of documentation by all parties plainly focused on what the nature of the "indigent care" arrangements actually was in practice, and whether CMS had agreed that FFP could be provided for supplemental payments based on those arrangements. If Movants had any relevant information about these issues, they were obliged to bring it forward earlier.

Movants similarly claim they are presenting new evidence "to correct the Board's misinterpretation" to show that the historical funding used in the UPL program was expected to continue under the waiver program. Joint Motion at 2. This issue too was directly presented in the original appeal and discussed at length in the decision. Board Decision 2886, at 26-28. Movants made the same claim before but failed to support it then with adequate evidence. *Id*. at 28 ("The State claims that CMS knew that the UC [uncompensated care] program under the waiver would be 'financed using those same funding mechanisms,' but the only basis it cites for this claim is a quotation from the waiver terms and conditions stating that '[p]rivate providers must have an executed indigent care affiliation agreement on file' which hardly identifies the specific practices which triggered this disallowance. Tex. Br. at 8 n.33 (quoting Tex. Ex. 11)."). Reconsideration is far too late in the process for Movants to seek to cure their evidentiary failures and omissions.

We conclude that none of the exhibits proffered by Movants are admissible at this point in the proceedings.

2. Movants fail to identify any clear error of fact.

Movants list six "factual errors" on which they assert that Board Decision 2886 is premised. Joint Motion at 2-3. (They do not allege any error of law.) Many of the allegedly erroneous findings stated in the Joint Motion, however, do not reflect actual findings in the decision but rather straw-man arguments based on how Movants wished to frame the dispute from the beginning. Where the Movants do identify a factual finding actually made by the Board, their contentions often amount to arguing that the Board should have given more weight or credence to their evidence or contentions than to those

of CMS, a position which does not amount to an allegation of clear error. In addition, even where Movants do quote words from actual Board findings, they frequently take those words out of context and ignore the surrounding discussions, or focus entirely on points that, even were they erroneous (which they fail to show), would not be material to the outcome. Furthermore, even if we accepted the late exhibits, none would demonstrate any clear error of fact. We reject Movants' allegations of error for these reasons, as explained below as to each of the six specific claims.

a. Movants do not show clear error in the Board's conclusion that CMS was not precluded from taking this disallowance based on its prior interactions with the State.

Movants allege the Board erroneously found that CMS was "ignorant from 2006 to 2014" about where the services to indigent persons were provided. Joint Motion at 4. Moreover, Movants contend the only basis for the Board's finding was acceptance of CMS's unsupported assertions. *Id*.

The Board did not find that CMS was "ignorant," nor did it treat the mere location of services as dispositive of whether the arrangements at issue provided an impermissible source of funds for the counties to use in making IGTs to draw down federal Medicaid funds. Movants point to the following excerpt, as quoted by Movants, from the Board's decision as supporting its claim of error:

> CMS contends that the assurances in the Prospective CoPs [Conditions of Participation], along with the repeated claims by the State that the AHs [Affiliated Hospitals] were merely "providing charity care" that did not "relieve an obligation" of the County HDs [Hospital Districts], led CMS to believe that the AHs were to provide care to indigent patients in their own facilities, rather than funding services in the County HD facilities. CMS Br. at 6 (and record citations therein). . . . In other words, CMS contends, with support in the record, that when it learned about problematic aspects of the arrangements, including that the AHs funded services in the County HD facilities and that those in-kind donations might be funding the IGTs, CMS took action and did not release the deferred funds until it was reassured that these concerns would not recur prospectively.

Joint Motion at 4 n.11 (quoting Board Decision 2886, at 27-28).

The omitted portion of the quotation reads: "Moreover, CMS requested and received assurances (from counsel for the State) that none of the funding for the IGTs would come from the provider donations. Tex. Ex. 10, at 1-2." Board Decision 2886, at 28. In other words, the Board was not finding that CMS was ignorant of the possibility that services might be provided at the county facilities but rather that the State provided repeated assurances and mixed signals to deflect concern about the intended practices by minimizing the extent to which the AHs had taken over a function otherwise executed by the county HDs. The full quotation further demonstrates the central concern was not where the services were being provided, but how those services were being financed. The central point was that limited disclosures mixed with ambiguous assurances led CMS to move forward despite persistent concerns about how the arrangements were related in practice to the source of funding for the IGTs.

The course of communications between the parties, reviewed in detail in the Board's decision, shows that the counties did not merely allow the AHs to use county facilities for private charity care. *See* Board Decision 2886, at 8-17 (and record citations throughout). Instead, the AHs undertook to pay for third-party service contracts that the counties would otherwise have funded, freeing up funds for the counties to draw down Medicaid payments ultimately used to make supplemental payments to the AHs. It is apparent in the Board decision that this conclusion was founded on a careful review of the evidence submitted by both parties, contrary to Movants' repeated claims that the Board accepted CMS's assertions "at face value." Joint Motion at 2, 4.

We are no more persuaded now than we were before that the limited disclosures to CMS regarding the location of services to indigent patients" listed in the Joint Motion prove that CMS was made fully aware of the specifics of the arrangements in practice. Joint Motion at 5-6. As explained in detail in Board Decision 2886, the full record shows that CMS repeatedly raised concerns about whether it was being given a complete picture of how the supplemental payments program worked in practice, culminating in deferrals of funds which were released only in reliance on an understanding that the State would take steps to respond to the concerns with changes. Board Decision 2886, at 26-28.

Movants seek to belatedly bolster their evidence that CMS was aware of the "collaboration and location" of services provided by the AHs by submitting a copy of a 2008 e-mail chain apparently among a CMS employee and individuals who were evidently representing the State in some discussions at the time. Joint Motion at 2 n.3 (citing Reconsideration Ex. A). We explained above that this exhibit is not admissible.

Even were this exhibit admitted, it would in no way advance Movants' arguments – the CMS employee is responding to an attached document described as a "Protocol" developed by the State in relation to the "private hospital UPL program." Reconsideration Ex. A at 1. The CMS employee responds that he is sending a tracked changes document reflecting comments and questions from both central and regional CMS staff. The tracked changes document reflects extensive alterations of, and concerns about, the content of the Protocol. *Id*., attached document passim. For example, CMS comments that: "Nowhere in this document is the redirection of Medicaid payments addressed. There should be assurance given that hospitals will retain 100% of the Medicaid payments and that hospitals will not fund the provision of services or anything else at other private hospitals or health care providers." *Id.*, attached document at 2. CMS questioned what the State meant by hospitals providing "indigent care" given that "private hospitals in all major metropolitan areas of Texas provided 'indigent care' by assuming physician coverage contracts from the local governments," and in one case even funded purchases of physician services and capital equipment for local government, "plus the amount the local government transferred on the private hospitals' behalf." *Id*., attached document at 1.

CMS also stated that certifications from the counties and AHs about how the arrangements would now operate under the new UPL system were not reassuring because numerous certifications had been submitted under the prior program "even though the local governments received funds directly from the hospitals." *Id*., attached document at 2. What is evident from this exchange is that, as of March 26, 2008, CMS continued to have major concerns and questions about what the State was proposing to do and whether it would reflect a "significant change in the operation of the program" responsive to CMS's concerns. *Id.*, attached document at 1.

b. *Movants do not show clear error in the Board's conclusion that CMS did not affirmatively approve the impermissible provider donations under the section 1115 waiver program*.

Movants assert that the Board erred in finding that CMS "did not approve the State's financing structure" when the State changed from the UPL program to the section 1115 waiver program. Joint Motion at 8. Movants do not cite to any such finding in Board Decision 2886. The Board explained that CMS had reason to be concerned about whether the actual practices had changed in a way that would ensure that non-federal funding of supplemental payments was not based on impermissible provider donations and expressly reserved in the demonstration waiver a right to review at any time the source of the non-federal funds. Board Decision 2886, at 29.

Here, too, Movants attempt to rely on newly-produced evidence that we have found to be inadmissible. Joint Motion at 8-9 (citing Reconsideration Ex. B). And here again, even were we to consider the exhibit, a 2011 email from a State official responding to questioning from CMS about the planned section 1115 waiver, it would not alter our conclusions. Movants argue that the State's response makes clear that the non-federal share for the entire waiver would be "generated through the same relationships used in" the UPL program. *Id*. Movants then extrapolate that CMS knew the "location of the private hospital indigent care services" in the UPL program and so would not have gone forward with the waiver unless they approved. *Id*. at 9.

A review of the email and attachments demonstrates that the State official merely named counties, hospital districts, and other public entities that might make IGTs for the waiver program and stated that those "transferring entities" are the same ones that historically participated in the UPL program. Reconsideration Ex. B (Answer to Funding Question 2.f). The State asserted that it did not know the amounts of transfers historically. Nothing in the exhibit communicates that AHs had provided, and would continue to provide, funding for maintaining physician coverage contracts for the public hospitals in at least two counties and thereby free the requisite funding for the counties' IGTs.

As stated above, this arrangement, not merely the location of services, is central to the finding of impermissible provider-related donations. Hence, the exhibits submitted by Intervenors before and cited in the Joint Motion that disclose that counties will contribute facilities or locations for the AHs to provide services did not, and still do not, persuade us that CMS knowingly approved AHs' related entities taking over physician coverage contracts for services to continue at the public hospitals. *Cf.* Joint Motion at 8 n.29, and record citations therein.

c. *Movants do not show clear error in the Board's finding that the AHs (through their non-profit corporations) took over contracts for physician coverage at the public hospitals previously paid for by the counties themselves.*

The Board found that "it is undisputed that the physician services contracts were often with the same health-care providers with which the County HDs had previously contracted to staff their hospitals." Board Decision 2886, at 18. The Board further explained that –

> passing the funding through the related entities does not make any relevant difference to the analysis, since donations may be direct or indirect. The essential core of the arrangement is that the **private hospitals pay to staff public hospitals**. Before entering into these arrangements, the County HDs paid to staff their own hospitals. By providing the staffing for those hospitals, the AHs provide in-kind replacement for the costs of staffing otherwise incurred by the County HDs just as surely as if they gave the County HDs money with which to pay for the staffing contracts. The contracts by the AHs to provide the physician services in the public hospitals therefore amount to in-kind donations to the County HDs operating the public hospitals.

Id. (bold in original).

Movants take issue with the use of the term "staff" in relation to physicians' role in hospitals. Joint Motion at 9. Movants even suggest that the Board was confusing the physician coverage contracts with hospital staffing privileges or the employment of non-physician staff members by the hospital. *Id*. They go on to reprise their positions in the original case that hospitals do not have an obligation to employ physicians, that Medicare reimburses hospital services separately from physician services, that physician services benefit patients not hospitals, and that the public hospitals merely provided facilities for the AHs' physicians to serve indigent patients. *Id.* at 9-11. They reason that the AHs could therefore not be paying to staff the public hospitals with physicians. Movants portray the relationship between the AHs and the counties instead as a simple one in which the AHs bear the costs of professional services and the counties bear the facility costs. *Id*. at 11.

These contentions continue to obfuscate what the Board explained was the "essential core of the arrangement." Board Decision 2886, at 18. That core is not based on any confusion about whether the physicians were hospital staff. The core is that counties paid to obtain physician services through third-party contracts (primarily with medical faculty of University of Texas or with other physician groups (*see, e.g.*, Tex. Ex. 25)) to provide indigent care in their public hospitals. Counties were relieved of that ongoing cost when the AHs through their related entities took over contracting (mostly with the same third parties) to continue providing the same services in the same public hospitals. While, as the Movants suggest, patients may indeed have benefited from receiving the physician services, no evidence indicates that patients received any greater benefit from shifting the costs of those services from the counties to the AHs (through their related entities).

To reiterate, this was not a situation of the AHs simply providing their required charity care and obtaining contribution of space in public hospitals to reach out to indigent patients. This was not a situation in which the counties were simply bystanders assisting the AHs to reach patients. The counties recognized revenue benefits that they explicitly accounted for as "[c]ontributed services revenue" based on the AHs' funding of the services in place of the prior contracts. CMS Ex. 13, at 49. Relying on these agreements, the counties then made the IGTs needed to draw down additional federal funding for Medicaid supplemental payments to the AHs. This circular practice thus merely shifted the cost of existing physician coverage from the counties to the AHs in a manner expected to more than reimburse the AHs for the costs incurred for the contracts. Such an arrangement is precisely what the law barring use of impermissible provider-related donations as non-federal share of Medicaid payments is meant to stop.

d. *Movants do not show clear error in the Board's statement that the State did not "directly dispute" that the counties obtained funding for the IGTs from resources freed by the arrangements at issue*.

The Board noted that CMS stated in its response brief that there remained "no dispute that the IGTs were derived" from the AHs' related entities funding the third-party physician coverage contracts such that the counties "had resources freed to make the IGTs to the State." Board Decision 2886, at 21 (quoting CMS Br. at 25). The Board observed that, in its reply brief, the State did not "directly dispute this statement." *Id*.

Movants state that they disagreed with that "characterization" of the IGTs and assert that they affirmatively stated there were "no provider-related donations." Joint Motion at 11-12. CMS's statement did not refer to whether provider-related donations occurred, a question settled in the affirmative elsewhere in Board Decision 2886. As far as the character of the IGTs, Movants merely aver that the State "demonstrated that the transferred funds were a permissible source of the nonfederal share." *Id.* at 12 (citing Tex. Br. at 20-28). As Board Decision 2886 explained at length, the State did not demonstrate that the funds it received from the counties were a permissible source of non-federal share. Movants, in any case, point to nothing in the State's reply brief (or even in the cited pages of the State's initial brief) that shows that the counties did not derive funds for the relevant IGTs from "contributed services revenue" associated with physician services paid for by the AH-related entities.

Movants claim that the Intervenors "negated" CMS's assertion in their reply and showed that the counties collected millions of dollars in ad valorem taxes. Joint Motion at 12 (citing Intervenors Reply Br. at 1-2). The undisputed fact that counties collect taxes does not negate CMS's statement that the counties' resources were freed by the AHs absorbing the physician coverage contract costs and that the freed resources sufficed to fund the counties' IGTs that covered the State's non-federal share of the supplemental payments to the AHs. In other words, the statement in the decision that the State did not directly dispute this fact is not erroneous. Even if it were erroneous and the State had articulated a dispute, the evidence of record does not establish that the counties' IGTs were somehow insulated from the counties' receipt of revenue released by replacing their contract costs by the AHs' undertaking to provide the contract coverage in their place.

e. *Movants do not show clear error in a Board conclusion as to the amount of IGTs allocated to individual hospitals*.

Citing page 24 of Board Decision 2886, Movants next assert that the Board erred in concluding that the counties "allocated IGTs based on the amount of support each hospital provided to" its respective related entity. Joint Motion at 12. As with many of Movants' claims of Board "errors," this argument begins by creating a straw-man description of a Board holding. Nowhere on the cited page does the Board make the conclusion set out by Movants.

What the Board concluded on that page was that a hold harmless practice existed based on multiple indicia. First, the record showed that, in practice, the counties had not made, and would not in the future make, IGTs to the State to provide non-federal share for supplemental payments to the AHs "if the AHs ceased to pay for the physician services in the County [hospital district] facilities, whether directly or through AH-related entities like TCICC and DCICC." Board Decision 2886, at 24. Second, the Board found that no evidence presented by the State or the Intervenors disproved the showing that, in practice, the counties allocated sufficient IGTs to "ensure that the AHs that provide the financing for the physician services" are able to "draw down at least as much in supplemental Medicaid payments as the AHs donate." *Id*. The Board found "disingenuous" the claim that a county would have no "obligation" to make IGTs to draw down supplemental payments for a private hospital that had not paid "any or all" of the county's hospital expenses, in light of the "uncontradicted reality that the IGT transfers were in practice dependent on the continued donations." *Id*. As the Board made clear, the relevant question is not whether the parties were **obligated** to continue their arrangements but what they **reasonably expected**, i.e., that if the AHs' related entities continued paying for

the physician coverage contracts for the counties' public hospitals, the counties would use the savings to make IGTs sufficient to draw down at least as much in supplemental payments to AHs as the costs of those contracts. *Id.* at 24-25 (noting that participants in the indigent care financing arrangement "based their actions on reasonable expectations" that donated services would trigger supplemental payments to the donor AHs). Finally, the Board pointed out that CMS has long provided notice that a hold harmless arrangement exists for purposes of the regulation when a provider making a tax payment or donation has a "reasonable expectation" of receiving all or part of the payment back. *Id*. at 24. The Board did not conclude, or consider, whether individual hospitals received supplemental payments calibrated precisely to their contributions to their respective related entities.[5]

Movants' further attempt to belatedly document that counties did not have access to specifics of payments made by the AHs to their non-profit entities is thus irrelevant, as well as inadmissible. Joint Motion at 13 (citing Reconsideration Exs. C, D and E). The Board's conclusions do not rest on findings that counties determined specific hospital contributions to related entities as the basis for allocating their IGTs (and hence the supplemental payments). Rather the conclusions rest on the entire set of practices and expectations that surround counties deriving revenue from impermissible provider-related donations and the State using that revenue to fund the non-federal share of supplemental Medicaid payments that participating hospitals expect to receive to reimburse those donations in whole or in part. Passing the donations through the related entities does not alter the underlying practice, and the regulations do not require each individual AH be guaranteed precise reimbursement. Movants have not shown that the related entities (which were obviously aware of the AHs' shares in their funding) did not communicate this information to the counties or the State, or that those entities did not play a role in determining the distribution of the supplemental payments. (CMS offered some basis to draw a contrary inference, CMS Response to Joint Motion at 9-10, but we need not, and do not, make any determination about this issue.)

None of the belated exhibits disprove that the cost of services provided to the county public hospitals by the related entities was positively correlated to the amounts of supplemental payments then distributed to participating AHs in practice, whether or not the specific amounts received by individual AHs may have been affected by other factors such as uncompensated care or charity care at their own facilities.

[5] Board Decision 2886 did note evidence in the record that AHs that "contribute[d] greater amounts to" TCICC or DCICC were "allocated more of the respective" IGTs (at page 23), and that IGTs were allocated in a way "sufficient to draw down at least as much in supplemental Medicaid payments as the AHs donate" (at page 24).

f. *Movants do not show clear error in the Board rejecting their claim that the disallowance was precluded by their belief that CMS agreed "that the State would have time to transition to new funding models*."[6]

Finally, Movants reprise the argument made in the original case that the disallowance is somehow improper because the State believed that CMS was still open to further negotiations when the State made the supplemental payments disallowed here. As with many of the recurring arguments discussed here, the Movants' actual position is somewhat amorphous and shifting. They explain the basis for this purported preclusion as quoted in the subheading above, but they also allege that they relied on "CMS's written assurances that the payment would not be at risk of disallowance." Joint Motion at 13. For this formulation, they cite only to the State's opening brief in the original appeal, not to any such written assurances. *Id*. at 13 n.50.

In the cited pages from the State's opening brief, the State asserted that CMS "confirmed" that "current funding arrangements would be allowed to continue for payments through August 2017, without risk of disallowance on the same grounds questioned in the 2014 deferral." Tex. Br. at 35 (citing Tex. Ex. 15). Texas Exhibit 15 consists of an email exchange (in May/June 2015) between a State employee and a CMS employee. The State employee said she understood from someone else that the CMS employee was "able to confirm with CMS' leadership that Texas will have until September 2017 to make any changes to private hospital funding that may be required following our scheduled discussions this summer." Tex. Ex. 15. She went on to state:

> By that, we understand CMS to authorize the current private-hospital funding arrangements to continue for waiver-payment dates through August, 2017, without risk of disallowance of federal matching funds on the same grounds questioned in last year's deferral. Waiver payments made to private hospitals after that date would be at risk if agreed-to changes are not made. We plan to start taking steps right away to implement any required changes, but this schedule recognizes the lengthy process that may be required at both local and state levels.

[6] Joint Motion at 13.

Id. The CMS official responds only that her "understanding of the timeline is correct." *Id*. That timeline would begin with the initiation of required changes after the discussions. As the Board found, no agreement to make changes was reached during the summer 2015 discussions, so the timeline for implementation was never triggered. *See* Board Decision 2886, at 29 n.15.

The State asserts in the same brief that it "believed that CMS would notify [the State] of its final determination after reviewing all of the information and documentation provided to CMS by the state," after discussions between the parties ended in the summer of 2015, but that it never got a final determination. Tex. Br. at 36 (citing Tex. Ex. 28). Texas Exhibit 28 consists of a September 2015 email from a CMS employee after the summer discussions ended, stating that CMS had "received all of the information" and that he did not "think we have any other questions that need to be answered. We are working with our leadership to discuss next steps." Tex. Ex. 28.

The State did not, and Movants do not now, present any evidence that the summer discussions resulted in any agreement about how the State would change its use of private hospital funding for nonfederal share or any evidence that the State took any steps as its employee stated it would to implement any such required changes. Movants ignore evidence in the record that the summer 2015 discussions in fact were unsuccessful in resolving the parties' differences or producing a plan for implementing changes necessary to make the funding arrangements compliant with federal law (as CMS understood it). Tex. Ex. 23. As a result, CMS proposed a "test case" to be brought to a "neutral arbiter" and indicated that the disallowance appealed to the Board in this matter was intended to serve that purpose. *Id*. at 2. (We note that the discussion of this disallowance as a test case is consistent with the disallowance being limited to a single quarter (ending December 31, 2015), despite CMS reserving the right to take additional disallowances if the State did not prevail in this appeal. *Id*. at 1-2.) It is apparent that discussion of a grace period until September 2017 was in the context of reaching some agreement on the changes to be made by the State and was for the purpose of allowing time for any necessary changes in State law and/or practice to be fully implemented. Nothing in the exhibits gave the State a basis to insist that it could continue for two more years with a funding mechanism that CMS had repeatedly informed the State violated federal Medicaid requirements in the absence of such an agreement.

We therefore find no error in the statement in Board Decision 2886 to which Movants object rejecting the State's "suggestion that it incurred these [disallowed] expenditures in reliance on assurances that it would have time to transition to other funding models because the deferral stated that Texas would be expected to 'make necessary adjustments by December 2015' or because during discussions CMS stated Texas might have 'until September 1, 2017 to make changes to the funding arrangements,' if required after discussions.'" Board Decision 2886, at 29 n.15 (record citations omitted).

Movants also assert error in the following statement:

> The State has not denied, however, that the discussions broke down in 2015 and that Texas did not undertake a new funding model or agree to make changes to the funding arrangements, or that CMS instead "proposed identifying a test case to get the issue before an independent arbiter" which led to the disallowance and this appeal. CMS Br. at 38-39 (quoting Tex. Ex. 23, at 4).

Joint Motion at 13-14 (quoting Board Decision 2886, at 29 n.15). Movants do not point to anywhere in the State's briefing below where the State actually denied that its discussions with CMS had broken down by September 2015, where it claimed to have undertaken a new funding model or agreed to effect changes, or where it disputed that CMS had proposed a test case.

Instead, Movants (belatedly again) attempt to make the arguments they apparently now think the State should have made. They argue that, on the one hand, the State did not need to take any steps, as promised, to implement changes right away, because no agreement was reached as to what changes were needed. Joint Motion at 14. On the other hand, they suggest that the advice that CMS leadership was considering next steps somehow implied that the final determination based on review of the State's information and positions at the end of summer 2015 would not be issuance of a disallowance. *Id*. at 14-15.[7] They assert that the State could not possibly have known from CMS's proposal to use a test case that a disallowance for the quarter ending December 31, 2015 might issue

[7] Here again, Movants cite another new and inadmissible exhibit that provides no support for their claims. Joint Motion at 15 n.57 (citing Reconsideration Ex. G). Reconsideration Exhibit G is another email from the State official who authored the May 29, 2015 email in Texas Exhibit 15, dated earlier in May 2015, to CMS officials proposing topics and a schedule for discussions during the summer of 2015. As explained above, the discussions did not yield agreement on needed changes, and the State did not undertake to implement any. The topics planned for the unsuccessful summer discussions have no relevance.

for that purpose. *Id*. at 15. Instead, they apparently believe the State could continue its practices after the discussions led to no agreement on the assumption that, despite plainly continuing to view the State's practices as contrary to federal law, CMS would take no adverse action at all for two more years. This theory, besides being too late, is not plausible and fails to show any error in the Board's statements. Moreover, even if we accepted that the State believed CMS would continue the discussions, the State made no showing that it would have behaved differently, or changed its practices for the quarter ending December 31, 2015, if CMS had only been clearer, so we cannot accept the allegation that the State relied to its detriment on its misunderstanding of CMS's intent. *Contra* Joint Motion at 14-15.

Ultimately, the entire issue of the accuracy of the statements in the Board's footnote is immaterial. The corresponding text in Board Decision 2886 to which the footnote Movants challenge was appended reads as follows:

> We also point out that, even had CMS knowingly permitted these arrangements at some point, the State has not shown that CMS would thereby be foreclosed permanently from revisiting concerns about the allowability of the supplemental payments under those arrangements. Recognizing the difficulty of asserting estoppel against the federal government, if it is available at all,[] the State and Intervenors disclaim any intention to assert that CMS is estopped by "its prior inconsistencies." Jt. Sur-surreply at 4. Indeed, as CMS points out, the terms of the waiver expressly provided that "CMS may review, at any time, the sources of the non-Federal share of funding for the Demonstration." CMS Br. at 34 (quoting CMS Ex. 4, at 65). The express reservation of this review authority reinforces CMS's ongoing concern about how these arrangements would be functioning in practice.

Board Decision 2886, at 28-29 (footnote omitted). In short, CMS would not be estopped from taking a disallowance authorized by law simply because the State believed that further forbearance and negotiations would occur prior to a disallowance.

Conclusion

For the reasons explained above, we deny Movants' reconsideration request.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Leslie A. Sussan
Presiding Board Member