DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Departmental Appeals Board
Appellate Division, MS-6127
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Washington, D.C. 20201

BY DAB E-FILE

October 3, 2019

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

Counsel:

Enclosed is a copy of the ruling of the Departmental Appeals Board in the matter identified above.

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-19-1
Request for Reconsideration of Decision No. 2886
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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