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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