Office of the Inspector General
Report of Investigation
21-06-014

Response 1

From: Langston, Brian
To: Anderson-Cordova, Roberto; Billington, Jeremy
Subject: Fwd: LIP Fund Fraud
Date: Tuesday, October 24, 2023 4:53:53 PM
Attachments: HHS-OIG Investigation of Jackson and LIP funding.pdf
Florida Agency for Health Care Administration, DAB No. 3031 (2021) | HHS.gov.pdf
AHCA summary of low income pool intergovernmental transfers (JR2675xA11F4).pdf
SKM_80823101712180.pdf
US ex rel [redacted] vs. North Brevard County Hospital District and Halifax Medical Center.pdf

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Sent from my iPhone

From: [redacted]
Sent: Monday, October 23, 2023 6:15 PM
To: Langston, Brian <Brian.Langston@ahca.myflorida.com>
Subject: LIP Fund Fraud

I reviewed your report. I would suggest we speak, before I respond in writing. You might want to review the attachments.

AHCA, Parrish and Halifax, acted improperly. Parrish and Halifax violated the anti-kickback statutes as a result of their application for LIP Funds. . We have filed a complaint in federal court which is attached.

Recently, HHS settled with AHCA and Jackson Memorial and I have attached the settlement agreement. AHCA and Jackson Memorial will be returning more than $400 million to HHS, for conduct which is no different that the conduct of Parrish and Halifax.

The below is from the HHS Appellate Board's ruling in the HHS vs AHCA matter:

According to Florida, considering the hospitals' LIP-eligible costs together would eliminate Jackson Memorial's LIP overpayments from both demonstration years 6 and 7 for which CMS determined Jackson Memorial had received payments in excess of its LIP Cost Limit, because the University of Miami hospitals were paid well under their LIP Cost Limits for those two years. Id. at 15, 16. Based on Florida's representations, Jackson Memorial accounts for $163,552,262 in payments in excess of the LIP Cost Limit for combined demonstration years 6 and 7 – a substantial majority of the $171,379,694 total payment in excess of the LIP Cost Limit attributable to all providers for demonstration years 1-7 encompassed in the January 2017 disallowance determination (A-17-64). Id. at 4. Florida's opening brief sets out the following table: Jackson/U. Miami Combined LIP Analysis Year Jackson Memorial Over/(Under) LIP Cost Limit University of Miami Hosp. Over/(Under) LIP Cost Limit U. of Miami Hospital/Clinics Over/(Under) LIP Cost Limit A.B. Leach Eye Hospital Over/(Under) LIP Cost Limit Combined 17 10/21/23, 6:31 AM Florida Agency for Health Care Administration, DAB No. 3031 (2021) | HHS.gov https://www.hhs.gov/about/agencies/dab/decisions/board-decisions/2021/board-dab-3031/index.html 21/27 DY 6 $78,364,371 ($84,159,754) ($8,746,313) ($15,734,282) ($30,275,978) DY 7 $85,187,891 ($94,419,820) Not calculated Not calculated ($9,231,929) FL Br. at 17; see also id. at 4 (table setting out the disallowed amounts at issue, by hospital provider, which indicates that the total amount allegedly paid to Jackson Memorial in excess of the LIP Cost Limit for demonstration years 6 and 7 is $163,552,262). Combining Jackson

Memorial's LIP Cost Limit with that of the University of Miami Health System, says Florida, would eliminate the disallowance attributable to Jackson Memorial, reducing the total disallowance amount attributable to the other providers to $4,709,951 in FFP. Id. at 17; Reply Br. at 8. Page 23 We see no language in either the STCs or the RFMD, and Florida points to none, that reasonably may be read as providing "flexibility" to treat the hospitals "on a combined basis for LIP purposes" (FL Br. at 17) based on the hospitals' integration or cooperation with one another, or for any reason. At best, Florida asserts that neither STC 97 (original) nor STC 57 (extension) (FL Ex. 1, at 25; FL Ex. 2, at 19) "specifically requires that [Florida] consider each hospital separately." FL Br. at 17. To redefine hospitals in some undefined flexible way retrospectively is not reasonable in the absence of some explicit basis in the STCs or RFMD. On the contrary, that "the RFMD . . . envisions a provider-specific cap" on LIP payments (Reply Br. at 7) contradicts Florida's claims. To allow Florida discretion to join hospitals in order to offset excess revenue at one against higher costs at another in effect would permit a hospital to exceed its specific cap and allow Florida to claim FFP in payments beyond that hospital's uncompensated costs. Florida's argument amounts to an after-the-fact attempt to eliminate a significant portion of its overall overpayment liability for excess LIP payments by having a hospital system that purportedly was paid well under the limit simply assume the overage amount attributable to a hospital that CMS says received payments well over the limit. We see no support for this attempt in the waiver terms and conditions to which Florida was bound. Florida again states that the RFMD, which Florida drafted, "presumably can be changed by Florida, subject to CMS approval." Reply Br. at 7-8. But Florida itself reports that it proposed to CMS that Jackson Memorial's and the University of Miami hospitals' LIP Cost Limits be considered together and that CMS rejected the proposal. FL Br. at 15. We note, moreover, that, under the STCs, any change to cost sharing, LIP, and FFP (all of which would be affected by this approach) not only must be approved in advance by CMS, it may not have retroactive effect. See FL Ex. 1, at 3 (¶ 6) and FL Ex. 2, at 4 (¶ 6) (both setting out STC 6, "Changes Subject to the Demonstration Amendment Process," stating that changes to, among other things, cost sharing, LIP, and FFP, must be submitted as amendments to the demonstration project and approved in advance by CMS and that amendments to cost sharing, LIP, and FFP are "not retroactive"). Florida may not now seek to retroactively 18 10/21/23, 6:31 AM Florida Agency for Health Care Administration, DAB No. 3031 (2021) | HHS.gov https://www.hhs.gov/about/agencies/dab/decisions/board-decisions/2021/board-dab-3031/index.html 22/27 eliminate Jackson Memorial's overage, having seen the outcome of applying the waiver under the agreed terms, by the expedient of creating a new combined provider entity retroactively for purposes of LIP calculations. CMS notes that, in accordance with the RFMD, each hospital is to rely on its Medicare cost report to determine appropriate costs, as follows: The CMS 2552 costs (Medicare cost report) determined through the method prescribed for the payment year will be reconciled to the as filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare Fiscal Intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the Federal Page 24 government and if an underpayment is determined, the State will make the applicable claim from the Federal government. CMS Response Br. at 14-15 (quoting FL Ex. 4 (RFMD), at 15). As CMS points out, Jackson Memorial and the University of Miami Health System submit separate Medicare cost reports, and each hospital that has received an overpayment is to properly credit it to the federal government. Id. at 15. CMS maintains that, even were it possible to combine the hospitals' cost reports, such an act would be inconsistent with the cost reporting process outlined in the RFMD. Id. Florida's reply does not respond to CMS's point that the cost reporting process as set out in the document that Florida itself prepared and agreed to by CMS would not support such a proposal. Conclusion The Board upholds CMS's decision to disallow

$97,570

Additionally, LIP funds are only meant to be used to help defray the hospitals' uncompenstated cost of providing care to low income individuals in Florida not for administrative costs. The testimony of Kent Bailey (in the AHCA IG report) is enough to confirm that the LIP funding request was a false claim. It funded administrative costs and a kickback/finders fee.

Also, by Florida Statute neither hospital, had authority to operate outside of its tax district regardless of whether there is an interlocal agreement in place. This has been confirmed by the Florida Supreme Court in a decision against Halifax Hospital.

My communications with attorneys from CMS in Atlanta, and a senior auditor from HHS, Lloyd Myers, further support the allegation that the conduct of AJCA, Halifax and Parrish was improper.

Recently, a number of transactions have been identified that were orchestrated by George Mikitarian, CEO of the North Brevard Hospital District/Parrish Medical Center and Jeff Feasel CEO of Halifax Medical Center in Volusia County. These financial transactions in which millions of dollars have been exchanged between these institutions, appear to be violate the False Claims Act. On the surface it appears that Halifax and Parrish conspired and game the system whereby hospitals receive state and federal money for providing care to low income patients. In doing so, they also appear to have conspired to launder government money and use these monies to fund projects for which the monies were not intended. The communications and internal memos between the two institutions indicate that they were aware of the risk of this conduct, understood that it was against the law and were aware that this conduct was done without proper authorization from government agencies. Additionally, Halifax was not authorized to provide services outside of Volusia County until May, 2019. What is even more worrisome is that this arrangement was transacted during the period of time in which Halifax was under a Corporate Integrity Agreement following payment in excess of $100 million for unrelated violations of the False Claims Act. It has also come to our attention that Parrish was advised by their attorneys that this conduct may have been in violation of the law. Yet, Dr. Mikitarian, ignored this advice and found attorneys who suggested that Parrish could probably “get away with it”

Attached is a brief summary of the interlocal agreement between Parrish and Halifax as well as the two agreements filed with the Clerk of Court. Here’s the Parrish description:

“The primary purpose of the interlocal agreement is to obtain $200,000 in increased Medicaid funding under the Low-Income Pool (LIP) program. The benefit to Halifax is to relieve it of excess LIP funds it would owe by designating LIP payments to other public hospitals. The arrangement will be submitted to the Florida AHCA to transfer LIP funds in their records.”

Under the 2017 arrangement, Halifax will wire transfer $4,434,000 to PMC. PMC will then transfer $4,234,000 to a Halifax account. PMC keeps $200,000 for providing care to Medicaid, underinsured and uninsured individuals.

This is the last paragraph in the memo from the PMC controller to the board:

“The interlocal agreement provides that Halifax will indemnify PMC for any loss associated with the transaction. The risk of loss for this agreement is very low.”

A similar arrangement in 2019 allowed PMC to keep $100,000. PMC transferred $1,527,500 back to Halifax

Florida law did not allow Halifax to engage is business outside of its district until May, 2019 and neither AHCA nor HHS approved the transaction described in the interlocal agreements. Furthermore, the Supreme Court of the State of Florida has opined on these interlocal agreements as being insufficient to justify breaking the law. This conduct was not approved by compliance officers at either institution.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FLORIDA MEDICAID PAID HUNDREDS OF MILLIONS IN UNALLOWABLE PAYMENTS TO JACKSON MEMORIAL HOSPITAL UNDER ITS LOW INCOME POOL PROGRAM

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Joanne M. Chiedi
Acting Inspector General

August 2019
A-04-17-04058

Office of Inspector General

https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: August 2019
Report No. A-04-17-04058

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program

Why OIG Did This Review

As part of its Research and Demonstration Waiver for Medicaid reform (the waiver), Florida established the Low Income Pool (LIP) program to compensate hospitals for providing care to low-income patients. During State fiscal years (SFYs) 2010 through 2014, hospitals received a total of $5.1 billion in LIP funds. Jackson Memorial Hospital (the Hospital) received $1.8 billion of this total.

The Centers for Medicare & Medicaid Services (CMS) performed reviews of the LIP program covering SFYs 2007 through 2009 and found that Florida did not provide adequate oversight and guidance. As a result, the hospitals claimed unallowable costs and inconsistently documented, calculated, and reported costs. Florida also had not refunded $146.1 million of Federal funds related to hospital-reported LIP overpayments disallowed by CMS.

Our objective was to determine whether Florida made LIP payments to the Hospital in accordance with the waiver and applicable Federal regulations.

How OIG Did This Review

Our audit covered SFYs 2010 through 2014, the most recent SFY for which supporting calculations were available. We reviewed the cost-limit calculations and supporting LIP data for unallowable items and clerical errors, and we recalculated the Hospital's cost limits for caring for low-income patients.

What OIG Found

Florida paid hundreds of millions to the Hospital under the LIP program that were not in accordance with the waiver and applicable Federal regulations. Of the $1.8 billion in LIP payments made to the Hospital during our audit period, Florida claimed Medicaid reimbursement of $686 million ($412 million Federal share) in excess of the Hospital's allowable costs, including $132 million ($64 million Federal share) of net Hospital-reported overpayments and $554 million ($348 million Federal share) of unallowable costs identified during this audit.

What OIG Recommends and Hospital and Florida Comments

We recommend that Florida (1) refund $412 million to the Federal Government, including $64 million of hospital-reported net overpayments and $348 million of unallowable costs identified during this audit; (2) instruct hospitals to establish procedures to return the Federal share of any overpayments in their LIP cost-limit calculations; (3) establish procedures to ensure that it returns to the Federal Government the Federal share of overpayments reported by hospitals; and (4) improve its oversight of the LIP program. We also made other procedural recommendations.

The Hospital disagreed with most of our findings. Most significantly, the Hospital contended that we incorrectly determined that it should offset Medicare and commercial insurance payments against costs for dual-eligible patients. After reviewing the Hospital's comments, we maintain that our findings and recommendations are correct, with one exception related to nonmedical assistance costs.

Florida disagreed with our findings. Like the Hospital, Florida argued that we incorrectly determined that the Hospital should offset Medicare and commercial insurance payments against costs for dual-eligible patients. Florida also argued that we did not properly consider the intersection of the LIP and disproportionate share hospital programs, contending that we should not have offset DSH payments that it had identified as overpayments. Florida also said that we should reduce Medicaid payments by the overpayment that it identified in its preliminary analysis of Medicaid rate settlements. After reviewing Florida's comments, we maintain that our findings and recommendations are correct but reduced the recommended refund from $436 million to $412 million based on additional information that Florida provided.

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INTRODUCTION

WHY WE DID THIS REVIEW

In 2005, the Centers for Medicare & Medicaid Services (CMS) approved Florida's Research and Demonstration Waiver (the waiver) for Medicaid reform. As a part of the waiver, the Florida Agency for Health Care Administration (State agency) established the Low Income Pool (LIP) program to compensate providers for the cost of care given to low-income patients. During State fiscal years[1] (SFYs) 2010 through 2014, 289 providers received $5.1 billion in LIP funds. Jackson Memorial Hospital (the Hospital) received $1.8 billion, which was more than 35 percent of total LIP funds paid in Florida and 3.6 times greater than the LIP funds paid to the recipient of the next highest amount. Beyond our audit period, the State agency paid LIP funds for SFYs 2015 through 2018 totaling $4.6 billion, of which the Hospital received $970 million, or approximately 21 percent. The amount that the Hospital received was about 3.4 times greater than the LIP funds paid to the recipient of the next highest amount.

CMS conducted two Financial Management Reviews of the LIP program covering SFYs 2007 through 2009 and found that the State agency did not provide hospitals with adequate oversight and guidance. As a result, the hospitals claimed unallowable costs and inconsistently documented, calculated, and reported costs. Additionally, for SFYs 2007 through 2014, CMS disallowed $146.1 million of Federal funds related to hospital-reported LIP overpayments that the State agency had not refunded.[2] On the basis of the risks that CMS identified and the Federal funds at stake, we conducted this review of LIP funds paid to the Hospital.

OBJECTIVE

Our objective was to determine whether the State agency made payments to the Hospital under the LIP program for SFYs 2010 through 2014[3] in accordance with the waiver and applicable Federal regulations.

[1] Florida's fiscal year is July 1 through June 30.

[2] The State agency has appealed CMS's disallowance.

[3] The audit period begins the first SFY after the period covered by CMS's Financial Management Reviews (SFYs 2007 through 2009). SFY 2014 was the most recent year for which cost-limit calculations were available when we began our audit.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance costs on the basis of the Federal medical assistance percentage, which varies depending on the State's relative per capita income. In Florida, the State agency administers the Medicaid program.

The Waiver

The State agency operates the waiver, which was approved by CMS under Title XIX, section 1115, of the Social Security Act (the Act). Section 1115 of the Act gives CMS authority to approve experimental, pilot, or demonstration projects that it considers likely to assist in promoting the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serve Medicaid populations.

To implement a State demonstration project, States must comply with the special terms and conditions (STCs) of the agreement between CMS and the State.[4]

Special Terms and Conditions

The STCs provide in detail the nature, character, and extent of Federal involvement in the waiver and the State's obligations to CMS during the life of the waiver.

Authorizations of the Low Income Pool Program

The waiver's STCs authorized the State agency to create the LIP program, which was to "be established and maintained by the [S]tate." The LIP program was to provide direct payments and distributions to safety-net providers in the State for providing healthcare

[4] Two versions of the STCs were in effect during the audit period: one effective July 1, 2009, through December 15, 2011 (STC-a) and the other effective for the remainder of the audit period (STC-b). CMS amended STC-b on June 14, 2013. The amended version did not materially change the requirements or provisions of the STCs cited in this report; however, it did change the item numbers. We have cited the amended version of STC-b.

services to Medicaid, underinsured, and uninsured populations. The initial authorization allowed for annual State-wide total LIP payments of up to $1 billion per year for SFYs 2007 through 2011. CMS has extended the LIP program several times, most recently through SFY 2022.

General Guidelines for Allowable Costs

The uncompensated costs of medical services for low-income patients, such as uninsured and Medicaid patients, are permissible LIP expenditures. Hospitals are to determine such incurred costs by using hospital Medicare cost report[5] methodologies (STC-a and STC-b, items 97 and 80, respectively). Also, the State may claim other costs, as agreed upon by the State and CMS (STC-a and STC-b, items 97 and 80, respectively). In addition, the STCs required the State agency to submit for CMS approval a Reimbursement and Funding Methodology Document (RFMD) that defined permissible LIP expenditures (STC-a, item 93).[6]

Reimbursement and Funding Methodology Document

The RFMD, along with the STCs, provides the primary governing guidance for the LIP program. In June 2009, the State agency submitted its RFMD; in December 2009, CMS approved it effective retroactive to July 1, 2006.[7] The RFMD defines the expenditures and entities, including certain hospitals, eligible to receive Federal matching. The RFMD provides instruction for calculating a hospital's cost limit, which is the portion of total allowable expenditures related to low-income patients, less any reimbursements received related to those patients. In addition to the RFMD, the State agency provided to hospitals a template (cost-limit calculation template[8]) and an instruction manual (LIP instruction manual) that reiterated the RFMD instructions for the cost-limit calculations.

[5] The Medicare cost report (Form CMS 2552) is a form that all hospitals must submit to CMS to determine program payments and support Federal program management.

[6] The STCs also discuss prescribed milestones that are not within the scope of this audit.

[7] The first RFMD (RFMD-a) ended June 30, 2011. During SFYs 2012 through 2014, two updated versions of the RFMD were in effect (RFMD-b and RFMD-c).

[8] The cost-limit calculation template is a Microsoft Excel spreadsheet that provides hospitals with the format for calculating the cost-limits and specific instructions regarding which Medicare cost report data to use in the calculations.

Distribution and Reimbursement Methodology

Distribution of Low Income Pool Funds

In 2005, the Florida Legislature established the LIP Council to, among other things, make recommendations on the financing of the LIP and the disproportionate share hospital (DSH)[9] programs and the distribution of those funds. During the audit period, the LIP Council consisted of 24 members from a variety of healthcare-related occupations. According to the RFMD, the LIP Council is responsible for making recommendations annually to the Florida Legislature regarding the distribution of LIP funds. Upon review and action by the Florida Legislature, the distribution methodology becomes part of the annual General Appropriations Act. Each year, the State agency may begin distributions in July, and the distributions are generally made monthly or quarterly.

Intergovernmental Transfers

For the audit period, 97 percent of the State share of LIP payments came from intergovernmental transfers (IGTs) from local governments.[10] The State agency entered into contracts with local governments to enforce its IGT agreements and assured local governments that the providers on whose behalf they sent IGTs would receive as much as or more in LIP payments than the amount of the IGTs.

Cost-Limit Calculations

To receive LIP distributions, hospitals are required to submit their LIP cost-limit calculations to the State agency annually. The LIP cost-limit calculations are due by March 1 of the second SFY after the SFY for which the calculation is being performed (e.g., a hospital's calculation for the SFY ended June 30, 2012, was due March 1, 2014). The State agency is required to submit these calculations to CMS 3 months later, by May 31.

Hospital Cost Portion of Calculations

The RFMD instructs hospitals to calculate the allowable costs for three types of low-income patients: Medicaid fee-for-service, Medicaid managed care, and uninsured or underinsured patients (all RFMDs, section IV (A)(1)(2)&(3)). Additionally, the State agency included Medicare dual-eligible[11] patients as a category of low-income patients on its CMS-approved cost-limit calculation template for hospitals to calculate costs.

[9] Federal law requires that States make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals (the Act §§ 1902(a)(13)(A)(iv) and 1923).

[10] The remaining 3 percent of the State share came from the State general revenue funds.

[11] Dual-eligible patients are patients who are entitled to Medicare and are also eligible for some form of Medicaid benefit.

To calculate inpatient routine costs, as well as inpatient and outpatient ancillary costs for each category of low-income patients, the RFMD instructs hospitals to perform the following steps:

determine the total hospital costs per day by inpatient routine cost center and the total cost-to-charge ratio by ancillary cost center;[12]

- multiply each inpatient routine cost center's low-income patient days[13] by the costs per day for the cost center; and

- multiply each ancillary cost center's inpatient and outpatient low-income charges by the cost-to-charge ratio for the cost center.

Additionally, the RFMD allows for hospitals to calculate organ acquisition costs for each category of low-income patient.

Hospital Provider Additional Medicaid Costs (Section 6 Costs)

Hospitals may include additional costs not included in the hospital LIP inpatient routine and ancillary costs (RFMD-a, section IV(A)(4), RFMDs b and c, section IV(A)(5)&(6)). In section 6 of its LIP cost-limit calculation template, the State agency included a separate section for these costs entitled "Hospital Provider Additional Medicaid Costs" (section 6 costs). These section 6 costs may include, for example, outpatient clinical laboratory services, patient and community education programs, and services contracted to other providers.

Payments Portion of Cost-Limit Calculations

Hospitals should reduce calculated costs by payments from the uninsured, Medicaid managed care organizations (MCOs), Medicaid, and other non-State payers. Also, Medicaid DSH and LIP payments should be included in the Medicaid payments that are being offset against costs (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). In addition, the LIP cost-limit calculations "may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments)" (STC-a, and STC-b, items 94 and 77, respectively).

Reconciliation to the Finalized Medicare Cost Report

[12] According to the RFMD, cost, days, and ancillary charges are to be taken from the Medicare cost report worksheets B part I, S-3, and C part I, respectively (all RFMDs, section IV (A)(1),(2),&(3)]). The data on these cost report worksheets are broken down into cost centers based on the hospital services to which they relate. Examples of inpatient routine service cost centers are the adult and pediatrics, intensive care, and coronary care units. Examples of ancillary cost centers are the operating room, recovery room, and radiology.

[13] Low-income patient days are the total of the days of service for all low-income patients during which those patients were inpatients in the hospital.

Ultimately, the State agency is required to reconcile the low-income costs calculated by the hospital to the costs calculated based on the finalized Medicare cost report for the payment year (RFMDs b and c, section IV(A)(9)).

Refund of Overpayments

The State agreed that it would not receive Federal financial participation (FFP) for payments to hospitals in excess of costs (STC-a, and STC-b, items 97 and 80, respectively, and all RFMDs, section IV). Additionally, the State must return to the Federal Government the Federal share of any overpayments made to the hospitals (RFMD-a, section IV(A)(7), RFMDs b and c, section IV(A)(9)).

Jackson Memorial Hospital

The Hospital is the largest teaching hospital in Florida and the only public hospital in Miami-Dade County. With about 1,500 beds, the Hospital is the largest facility operated and managed by the Public Health Trust of Miami-Dade County, Florida (PHT). PHT was created by the Board of County Commissioners pursuant to Florida statute and county ordinance and receives part of its funding from a healthcare surtax.[14] PHT's patients are primarily Medicaid or other publicly funded residents, and its facilities treat the uninsured and underinsured, as it operates the only safety-net hospital in the county.

HOW WE CONDUCTED THIS REVIEW

Our audit covered SFYs 2010 through 2014 (audit period). We focused our review on the Hospital, which received the largest amount of LIP payments, $1.8 billion, or approximately 35 percent of the State-wide total, with the second-ranking hospital receiving only about 10 percent of LIP funds. We reviewed the cost-limit calculations and the supporting LIP data to identify any unallowable items or clerical errors, and we recalculated the Hospital's cost limits to determine the amount the State agency paid the Hospital in excess of its costs of caring for low-income patients.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[14] Florida Statute, Title XIV, chapter 212, section 212.055, Discretionary Sales Surtaxes, authorizes the imposition of a discretionary sales surtax. Under § (5), County Public Hospital Surtax, a 0.5-percent sales surtax was voted on and approved for the administration of the county public general hospital and the public health trust that operates it.

See Appendix A for the details of our scope and methodology and Appendix C for applicable Federal requirements.

FINDINGS

The State agency paid hundreds of millions to the Hospital under the LIP program that were not in accordance with the waiver and applicable Federal regulations. Of the $1,798,392,602 in LIP payments made to the Hospital during our audit period, $1,112,047,198 was allowable. However, the remaining $686,345,404 ($411,932,576 Federal share) that the State agency claimed for Medicaid reimbursement was for payments in excess of the Hospital's allowable costs as follows:

- $131,983,013 ($64,382,543 Federal share) of net Hospital-reported overpayments for the audit period, consisting of $245,783,531 ($141,036,263 Federal share) of overpayments for SFYs 2012, 2013, and 2014[15] that the State agency did not refund and $113,800,518 ($76,653,720 Federal share) of underpayments for SFYs 2010 and 2011;

- $222,650,251 ($141,527,826 Federal share) related to omitted and underreported payments:

    - Medicaid payments of $134,108,689 ($87,390,030 Federal share) and

    - Medicare payments of $88,541,562 ($54,137,796 Federal share) for dual-eligible patients;

- $142,311,325 ($88,075,549 Federal share) related to caring for patients for whom Federal funding was not available:

    - costs of $136,736,903 ($84,538,219 Federal share) related to the non-emergency care of undocumented aliens and

    - costs of $5,574,422 ($3,537,330 Federal share) related to the outpatient care of prisoners;

- $67,905,785 ($39,008,490 Federal share) of unallowable costs that were not calculated in accordance with RFMD guidance:

    - $37,320,247 ($21,390,528 Federal share) related to excluded low-income cost data,

    - $14,083,369 ($5,627,904 Federal share) related to incorrectly distributed low-income data,

[15] As of December 10, 2018, the State agency had not yet returned the Federal share of these hospital-reported overpayments.

- $11,411,642 ($7,396,731 Federal share) related to incorrectly calculated observation bed costs, and

- $5,090,527 ($4,593,327 Federal share[16]) related to incorrectly calculated organ acquisition costs;

- $51,889,200 ($31,955,859 Federal share) of unallowable section 6 costs:

  - incorrectly included costs totaling $36,262,973 ($22,864,006 Federal share) for nonmedical assistance,

  - incorrectly included costs totaling $14,310,216 ($8,256,930 Federal share) for caring for prisoners in a prison facility, and

  - incorrectly included costs totaling $1,316,011 ($834,923 Federal share) for other than low-income patients;

- $48,044,340 ($31,898,767 Federal share) related to clerical errors in reporting LIP data, including $42,427,589 of overstated low-income ancillary charges for SFY 2010; and

- $21,561,490 ($15,083,542 Federal share) of costs that the State agency did not reconcile to the Hospital's finalized Medicare cost reports.

See Appendix B for a summary of these findings by year and total.

The State agency did not return the Federal share of overpayments reported by hospitals because it did not have a procedure in place to do so. Also, the State agency claimed excessive reimbursement because it had not established policies for the oversight of the LIP program to ensure that it could identify and correct instances in which hospitals overstated their cost limits. Finally, the Hospital did not have adequate policies and procedures for preparing and reviewing cost-limit calculations and did not have any procedures to ensure that it returned to the State agency the Federal share of any overpayments that the Hospital identified.

THE STATE AGENCY DID NOT RETURN THE FEDERAL SHARE OF THE HOSPITAL'S SELF-REPORTED OVERPAYMENTS

The State agency agreed that it would not receive FFP for Medicaid and LIP payments to hospitals in excess of costs (STC-a and STC-b, items 97 and 80, respectively). CMS may reduce funds available through the LIP to recoup payments made to providers that it determines were

[16] The Federal share percentage is higher in this instance because a substantial portion of the overpayment was in 2010, a year in which there was a significantly enhanced Federal share percentage.

made in excess of allowable costs and may recoup funds through a reduction of FFP claimed against LIP payments or through disallowance (STC-b, item 75).
Additionally, the State agency must ensure that the total costs claimed in a State plan rate year do not exceed the costs justified in the underlying hospital cost reports for the applicable years (RFMD-a, section IV(A)(7), RFMDs b and c, section IV(A)(9)).

For SFYs 2012 through 2014, the Hospital self-reported overpayments (payments in excess of allowable costs) totaling $245,783,531 ($141,036,263 Federal share). In September 2016, CMS issued a demand letter for the Federal share of State-wide hospital-reported overpayments for SFYs 2007 through 2014.[17] As of December 10, 2018, the State agency had not yet paid the amount demanded by CMS.

The Hospital also reported underpayments for SFYs 2010 and 2011 totaling $113,800,518 ($76,653,720 Federal share). In its demand letter, CMS did not offset the self-reported overpayments with these underpayments because neither the STCs nor the RFMD has a provision for settlement payments to hospitals for years in which they are underpaid. However, we determined that the Hospital now has net overpayments for all SFYs in the audit period, including SFYs 2010 and 2011 which had previously been underpayments. Therefore, the $76,653,720 Federal share of self-reported underpayments should be netted against the $141,036,263 Federal share of self-reported overpayments, resulting in a net self-reported overpayment of $64,382,543.

The State agency did not have procedures to ensure that it returned the Federal share of overpayments reported by hospitals. Additionally, the Hospital did not have procedures to ensure that it returned to the State agency the Federal share of any calculated overpayments that the Hospital identifies.

THE HOSPITAL OMITTED AND UNDERREPORTED MEDICAID AND MEDICARE PAYMENTS

The Hospital incorrectly omitted and underreported Medicaid and Medicare payments totaling $222,650,251 ($141,527,826 Federal share) in its cost-limit calculations.

Medicaid Payments

Hospitals must include all Title XIX payments, including DSH payments, as offsetting payments against calculated low-income costs (STC-a, and STC-b, items 94 and 77, respectively). Additionally, hospitals must offset LIP payments received during the year for which the LIP cost-limit calculation is being performed (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)).

In its cost-limit calculations, the Hospital did not offset $134,108,689 it received in Medicaid payments against low-income costs. Specifically, the Hospital received $83,256,130 in Medicaid

[17] In total, CMS demanded $146,113,363, which included $141,036,263 related to the Hospital. The State agency has appealed CMS's disallowance.

DSH payments in SFY 2010 that it did not offset, understated LIP payments by $21,393,680 from SFYs 2010 through 2014, and received $29,458,879 for the care of Medicaid patients not identified with specific claims in SFYs 2010 and 2014 that it did not offset (Table 1).

Table 1: Omitted and Underreported Payments in the Hospital's Cost-Limit Calculations

Payment Type	Amount	State Fiscal Year(s)
Diagnosis-related group transitional[18]	$17,487,543	
Additional funding of inpatient and outpatient rates[19]	9,373,381	
Organ acquisition costs	2,597,955	
Subtotal—Medicaid payments not for specific claims	**$29,458,879**	2010–2014
Medicaid DSH	83,256,130	2010
LIP	21,393,680	2010–2014
Total Medicaid Payments Not Offset	**$134,108,689**	

As a result of the Hospital overstating its cost-limits by $134,108,689, the State agency received an overpayment of $87,390,030 from the Federal Government.

The State agency received the overpayment for the omitted DSH payments and the underreported LIP payments because it did not provide proper oversight by testing or verifying the accuracy of the LIP data the Hospital used in its cost-limit calculations. The State agency should have been able to readily identify the Hospital's omission of DSH payments and understatement of the LIP payments if it had reviewed the data the Hospital used.

The State agency claimed the unallowable reimbursements related to the non-claim-specific Medicaid payments because it did not instruct hospitals to include these payments in the LIP cost-limit calculations. Additionally, although the State agency included a section in its cost-limit calculation template for hospitals to include DSH and LIP payments, it neither included a section to record other non-claim-specific Medicaid payments nor reviewed the cost-limit calculations to verify that the Hospital included such payments.

Also, contrary to the instructions in the STCs, the Hospital did not consider all Medicaid payments when it was calculating its cost limits. Hospital personnel said that for SFY 2010 they omitted the Medicaid DSH payments because they assumed that the State would automatically include the payments. However, for SFYs 2011 through 2014, they correctly reported the Medicaid DSH payments.

[18] In SFY 2014, the State agency changed its claims reimbursement methodology from per diem payments to payments based on diagnosis-related groups. These transitional payments made in SFY 2014 were designed to aid hospitals that experienced a decrease in reimbursement due to the change in methodology.

[19] This payment represented a one-time adjustment to increase the rates paid to the Hospital for inpatient and outpatient services.

Medicare Payments for Dual-Eligible Patients

The RFMD instructs hospitals to calculate allowable costs for three types of low-income patients: Medicaid fee-for-service, Medicaid managed care, and uninsured or underinsured patients (all RFMDs, section IV(A)(1)(2)&(3)). In its CMS-approved cost-limit calculation template, the State agency also allowed hospitals to include Medicare dual-eligible patients as a category of low-income patients.

To calculate allowable costs, hospitals should offset costs for these patients with payments from the uninsured, Medicaid MCOs, Medicaid, and payments from other non-State payers (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). Similarly, hospitals should use the portion of payments attributable to Medicare dual-eligible patients to offset their uncompensated care costs. Medicare makes payments to hospitals for (1) individual Medicare patients, including Medicare dual-eligible patients; (2) tentative and final settlement of their Medicare cost reports; and (3) separate payments for direct graduate medical education, Medicare bad debts, and organ acquisition costs.

For our audit period, the Hospital did not offset against its low-income costs $88,541,562 for the Medicare dual-eligible patients' portion of Medicare payments for tentative and final cost report settlements, direct graduate medical education, Medicare bad debts, and organ acquisition costs. As a result of understating payments received, the Hospital overstated its LIP cost limits by $88,541,562, and the State agency received an overpayment of $54,137,796 from the Federal Government.

The State agency received this overpayment because it did not instruct hospitals to include in their LIP cost-limit calculations some payments associated with Medicare dual-eligible patients. Also, the State agency neither included in its cost-limit calculation template a section in which hospitals could report these payments nor reviewed the calculations to verify that the Hospital included such payments.

THE HOSPITAL CLAIMED COSTS FOR PATIENTS FOR WHOM FEDERAL FUNDING WAS NOT ALLOWABLE

The Hospital incorrectly claimed a total of $142,311,325 ($88,075,549 Federal share) for categories of patients for which Federal funding is not allowable. These patients were undocumented aliens or prisoners being treated on an outpatient basis.

Care Provided to Undocumented Aliens

The Act § 1903(v)(1) prohibits payments to States for medical assistance to an alien who is not lawfully admitted for permanent residence to the United States or otherwise permanently residing in the United States under color of law (i.e., "undocumented aliens"). However,

§ 1903(v)(2) provides an exception to this rule for the cost of emergency care provided to undocumented aliens. LIP funds cannot be used for costs associated with the provision of healthcare to non-qualified aliens (STC-a and STC-b, items 95 and 78, respectively).

For each of the 5 years in our audit period, the Hospital included the unallowable costs of non-emergency care[20] for undocumented aliens in its cost-limit calculations. The Hospital identified these patients as undocumented aliens when assigning them to a financial class in the Hospital's accounting records.

As a result of improperly including in its cost-limit calculations the unallowable costs of non-emergency care for undocumented aliens, the Hospital overstated its cost limits by $136,736,903, and the State agency received an overpayment of $84,538,219 from the Federal Government.

The State agency received this overpayment because it did not instruct hospitals to exclude the costs of non-emergency care for undocumented aliens. Also, the State agency did not provide proper oversight by checking the Hospital's documents, which clearly identified the "undocumented aliens" financial class for many claims used in the cost-limit calculation.

Outpatient Care Provided to Prisoners

The cost of inpatient care provided to prisoners is allowed, but hospitals should not include in their cost-limit calculations the costs of care for prisoners in other than an inpatient setting (STC-a and STC-b, items 94 and 77, respectively; the Act § 1905(a)(29)(A); and December 12, 1997, CMS Director letter ("Clarification of Medicaid Coverage Policy for Inmates of a Public Institution")).

For our audit period, the Hospital included, in its low-income data, claims for outpatient care provided to prisoners. The Hospital separately identified these patients as prisoners when assigning them to a financial class in the Hospital's accounting records. The Hospital also included in its section 6 costs for SFYs 2012 through 2014 the costs related to the care of prisoners provided at prison facilities. (See "The Hospital Claimed Unallowable Section 6 Costs" below.)

As a result of including the unallowable costs of providing care to prisoners in outpatient settings, the Hospital overstated its LIP cost-limit calculations by $5,574,422,[21] and the State agency received an overpayment of $3,537,330 from the Federal Government.

[20] The Hospital also included the costs of emergency care for undocumented aliens, which was allowable.

[21] This figure does not include the cost of caring for prisoners in a prison facility, which we have addressed in another finding. (See page 17.)

The State agency received this overpayment because it did not instruct hospitals to exclude the costs of caring for prisoners in outpatient settings. Also, the State agency did not provide proper oversight by testing or verifying that the Hospital was not including unallowable costs of caring for prisoners in its LIP cost-limit calculation. Hospital personnel stated that nobody at the Hospital reviewed the low-income data to determine whether claims for outpatient care provided to prisoners were included. If the State agency had reviewed the Hospital's supporting list of low-income claims, it would have identified the errors because the Hospital identified the financial classes for each line item on the list.

THE HOSPITAL DID NOT FOLLOW SOME REIMBURSEMENT AND FUNDING METHODOLOGY DOCUMENT INSTRUCTIONS

The Hospital did not follow RFMD instructions regarding (1) calculating costs for all low-income patients, (2) distributing low-income data consistent with the Medicare cost report methodology, (3) calculating organ acquisition costs, or (4) calculating low-income observation bed costs. As a result, the Hospital overstated its cost-limit calculations by $67,905,785 ($39,008,490 Federal share).

Excluded Some Low-Income Patient Data

The RFMD instructs hospitals to calculate the cost shortfall (i.e., costs in excess of payments) for Medicaid fee-for-service, Medicaid managed care, and uninsured or underinsured patients (all RFMDs, section IV(A)(1), (2), and (3); also RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). In its CMS-approved LIP cost-limit calculation template, the State agency also allowed for hospitals to include Medicare dual-eligible patients as a category of low-income patients.

For SFYs 2011, 2012, and 2013, rather than including in its cost-limit calculations the data for all patients from the four low-income categories, the Hospital excluded certain low-income patient accounts for which it estimated payments exceeded costs. This omission distorted the amount by which the Hospital's overall costs exceeded payments (i.e., its LIP cost limit) for the applicable categories of low-income patients. As indicated in Table 2 below, if the Hospital had correctly included these accounts, it would have increased its allowable costs by $127,365,471, but this cost would have been offset by payments totaling $164,685,718, resulting in a net decrease to the Hospital's cost limits of $37,320,247.

Table 2: Patient Data Excluded From Hospital Calculations

Low-Income Category	Costs for Excluded Accounts*	Payments Received	Payments > Costs
SFY 2011			
Dual-eligibles	$14,938,567	$21,220,700	$6,282,133
Medicaid MCO	9,997,498	7,993,754	(2,003,744)†
Total SFY 2011	**$24,936,065**	**$29,214,454**	**$4,278,389**
SFY 2012			
Dual-eligibles	$63,388,150	$80,214,938	$16,826,788
Out-of-State Medicaid	750,720	1,028,754	278,034
Medicaid MCO	29,204,664	38,622,898	9,418,234
Total SFY 2012	**$93,343,534**	**$119,866,590**	**$26,523,056**
SFY 2013			
Uninsured	$9,085,872	$15,604,674	$6,518,802
Total All Years	**$127,365,471**	**$164,685,718**	**$37,320,247**

* The costs represent the increase in total low-income costs when we added the patient days and ancillary charges for the excluded accounts to the cost-limit calculations.

† The Hospital excluded these accounts for which it estimated the payments exceeded costs. However, for these particular accounts, the actual costs exceeded payments.

As a result of improperly excluding certain low-income patients from its data, the Hospital overstated its LIP cost limit by $37,320,247, and the State agency received an overpayment of $21,390,528 from the Federal Government.

The State agency received this overpayment because it did not provide proper oversight by testing or verifying the completeness of data being used by the Hospital in its LIP cost-limit calculations. Additionally, Hospital personnel said that, because the excluded patient data involved significant payments, they did not think it was proper to include the patient data in the LIP cost-limit calculations.

Incorrectly Allocated Low-Income Data Used To Calculate Costs

The RFMD instructs hospitals to calculate low-income costs by multiplying low-income patient days and ancillary charges by specified cost factors derived from the Medicare cost report (all RFMDs, section IV(A)(1),(2), and (3)). Additionally, the STCs state that permissible expenditures are to be derived utilizing methodologies from the Medicare cost report. This instruction is

repeated in the RFMD. To calculate its low-income costs consistent with the Medicare cost report, the Hospital should have allocated low-income patient days and ancillary charges in its cost-limit calculations to cost centers in the same manner as it distributed those patient days and ancillary charges within the total patient days and total ancillary charges on its Medicare cost reports. Otherwise, low-income costs may exceed total hospital costs for certain cost centers.

In its cost-limit calculations for each SFY in our audit period, the Hospital distributed more low-income patient days and ancillary charges to certain cost centers than there were total hospital patient days and ancillary charges for those cost centers. This distribution resulted in calculated low-income costs that exceeded total hospital costs for those cost centers.

As a result of its incorrect distribution of the low-income patient data, the Hospital overstated its cost-limit calculations by $14,083,369, and the State agency received an overpayment of $5,627,904 from the Federal Government.

The State agency received this overpayment because it did not provide adequate oversight by testing or verifying the accuracy of the Hospital's LIP cost-limit calculations. Specifically, even a cursory review by the State agency would have revealed that the low-income costs exceeded total costs in certain cost centers.

In addition, the State agency did not have basic electronic edits in place to detect low-income costs exceeding total costs.

Hospital personnel stated that low-income costs exceeded total costs for certain cost centers because they used the Medicaid low-income data allocation percentages to distribute the low-income data for the Medicaid managed care, uninsured, and Medicare dual-eligible patients.

Incorrectly Calculated Low-Income Observation Bed Costs

The RFMD instructed hospitals to include observation bed-days[22] in the total inpatient day count for purposes of calculating the total inpatient routine cost per day and to include low-income observation charges in the calculation of low-income ancillary costs (all RFMDs, section IV(A)(1),(2), and (3)).

The Hospital did not include observation bed-days in its calculation of the inpatient routine costs per diem in any of its cost-limit calculations in our audit period. In addition, for certain years, the Hospital did not include the observation cost center in its calculation of low-income ancillary costs.

[22] Observation services are hospital outpatient services a patient receives while the patient's doctor decides whether to admit the patient.

As a result of not including observation bed-days in the routine costs per diem calculation and not including the observation cost center in the low-income ancillary cost calculation, the Hospital overstated its LIP cost limit by $11,411,642, and the State agency received an overpayment of $7,396,731 from the Federal Government.

The State agency received this overpayment because it did not check or verify that the Hospital properly incorporated observation days and charges into its cost-limit calculations, as the RFMD required.

Incorrectly Calculated Organ Acquisition Costs

The RFMD instructs hospitals to identify the ratio of usable organs for low-income patients (from hospital records) to total usable organs (from the Medicare cost report). The RFMD then instructs the hospitals to multiply that ratio by total organ acquisition costs from the Medicare cost report to arrive at the allowable low-income patient organ acquisition costs (all RFMDs, section IV(A)(1),(2),and (3)).

For SFYs 2010 and 2011, the Hospital did not follow the methodology prescribed by the RFMD and instead incorrectly calculated its low-income organ acquisition costs by multiplying low-income charges by the cost-to-charge ratio for the specific organ acquisition cost centers. In addition, for SFY 2010, the Hospital incorrectly claimed that all of its organ acquisition costs were for low-income patients.

The Hospital used the correct methodology to calculate organ acquisition costs for the other 3 years in the audit period; however, the figures it used in the calculations did not agree with the finalized Medicare cost reports.

As a result of the Hospital overstating its LIP organ acquisition costs by $5,090,527 on its LIP cost-limit calculations, the State agency received an overpayment of $4,593,327 from the Federal Government.

The State agency received this overpayment for improperly calculated organ acquisition costs because it did not ensure that the Hospital used the RFMD-prescribed method for calculating low-income organ acquisition costs. Additionally, the State agency had no procedures in place to review the calculations and did not verify the organ counts data and organ acquisition costs used by the Hospital for the years that the Hospital calculated the costs using the proper methodology.

THE HOSPITAL CLAIMED UNALLOWABLE SECTION 6 COSTS

The Hospital included costs in its section 6 costs that were not in compliance with the RFMD. Specifically, it included costs that were (1) not for medical assistance, (2) for caring for prisoners in prison facilities, (3) not reduced by payments received, and (4) not for low-income patients.

In total, the hospital claimed $51,889,200 of unallowable section 6 costs ($31,955,859 Federal share).

Nonmedical Assistance Costs

In defining permissible expenditures, the STCs say that LIP funds may be used for healthcare costs (medical care costs or premiums) within the definition of medical assistance in § 1905(a) of the Act.

As noted in Table 3, for our audit period, the Hospital made errors in its cost-limit calculations by including a total of $36,262,973 in costs that did not qualify as "medical assistance,"[23] as defined in section 1905(a) of the Act.

Table 3: Nonmedical Assistance Costs in Cost-Limit Calculations

Cost Item	Total Cost
Jackson International*	$25,129,748
Toddler shelter day care	6,839,245
Jail rapid transit	2,278,116
Jail diversion	1,853,014
Forensic evaluation	162,850
Total	**$36,262,973**

* Jackson International is a program designed to lead international patients to providers who can treat their complex medical conditions.

As a result of these errors in the Hospital's cost-limit calculations, the State agency claimed unallowable Federal reimbursement totaling $22,864,006.

The State agency received this overpayment for section 6 costs that were not for medical assistance because it did not evaluate the nature of the section 6 costs that the Hospital claimed.

Costs of Caring for Prisoners in a Prison Facility

The cost of inpatient care provided to prisoners is allowed, but hospitals should not include in the cost-limit calculations the costs of care for prisoners in other than an inpatient setting (STC-a and STC-b, items 94 and 77, respectively; the Act § 1905(a)(29)(A); and December 12,

[23] Medical assistance under a State's Medicaid State Plan for which it may receive Federal payments includes inpatient and outpatient services, as well as other medical services for Medicaid beneficiaries.

1997, CMS Director letter ("Clarification of Medicaid Coverage Policy for Inmates of a Public Institution")).

For 3 years in our audit period, the Hospital included in the section 6 part of its cost-limit calculations costs totaling $14,310,216 that were for caring for prisoners in a prison facility instead of a hospital inpatient setting. As a result of the Hospital incorrectly including these costs, the State agency received an overpayment of $8,256,930 from the Federal Government.

The State agency received this overpayment for section 6 costs that were for caring for prisoners at a prison facility because it did not evaluate the nature of the section 6 costs that the Hospital claimed.

Medical Assistance for Other Than Low-Income Patients

The STCs require LIP funds to be used for the provision of care to low-income patients (STC-a and STC-b, items 94 and 77, respectively).

For our audit period, the Hospital's cost-limit calculations included in its section 6 costs the costs of a physician's private office that did not service primarily low-income patients. The total of such costs that the Hospital claimed was $1,316,011. As a result of the Hospital incorrectly including these costs, the State agency claimed unallowable Federal reimbursement totaling $834,923.

The State agency received this overpayment because it did not instruct hospitals to review section 6 costs for allowability based on the RFMD, and it did not review the Hospital's section 6 costs.

THE HOSPITAL MADE SEVERAL CLERICAL ERRORS

The RFMD instructs hospitals to calculate low-income costs by multiplying low-income patient days and ancillary charges by cost factors derived from the Medicare cost report (all RFMDs, section IV(A)(1), (2), and (3)).

The Hospital made several clerical errors in its LIP cost-limit calculations for SFYs 2010, 2011, 2013, and 2014. The most significant of these errors was related to its calculation of low-income ancillary charges for SFY 2010, which caused the Hospital's SFY 2010 cost-limit calculation to be overstated by $42,427,589. Hospital personnel said that they used an incorrect formula to obtain the low-income inpatient routine charges. They incorrectly obtained only 1 day's per diem inpatient routine charge for each line of low-income data, rather than obtaining the total inpatient routine charges for the entire hospital stay. The Hospital then subtracted inpatient routine charges from total charges to calculate ancillary charges. This calculation caused the gross overstatement of low-income ancillary charges.

The Hospital's other clerical errors caused its cost limits for SFYs 2011, 2013, and 2014 to be overstated by another $5,616,751. In total, the Hospital overstated its cost-limit calculations by $48,044,340 because of clerical errors. As a result, the State agency received an overpayment of $31,898,767 from the Federal Government.

The State agency received this overpayment because it did not provide adequate oversight by testing or verifying the accuracy of the low-income patient data, including patient days, ancillary charges, and payments, that the Hospital used in its LIP cost-limit calculations. Specifically, for SFY 2010, if the State agency had checked the amounts of low-income ancillary charges, it would have recognized that the Hospital had a noticeable error in its cost-limit calculations.

THE STATE AGENCY DID NOT RECONCILE THE HOSPITAL'S COST-LIMIT CALCULATIONS TO FINALIZED MEDICARE COST REPORTS

The State agency must reconcile the hospital cost limits to the finalized Medicare cost report for the payment year (RFMDs b and c, section IV(A)(9)).

The State agency did not reconcile (i.e., update) the Hospital's cost-limit calculations based on the finalized Medicare cost reports, causing its cost-limit calculations to be overstated by $21,561,490. As a result, the State agency received an overpayment of $15,083,542 from the Federal Government.

The State agency received this overpayment because it did not perform the required reconciliations and because it did not have controls in place to ensure adherence to the requirements of the RFMD. Additionally, the State agency explained that, because its share of the LIP funds is provided almost entirely through IGTs, it has no risk and no incentive to identify overpayments after LIP payments are made.

RECOMMENDATIONS

We recommend that the State agency:

- refund $411,932,576 to the Federal Government, consisting of:
    - $64,382,543, representing the Federal share of net Hospital self-reported LIP overpayments for the audit period and
    - $347,550,033, representing the Federal share of LIP cost limits calculated by the Hospital that did not comply with Federal and State requirements as identified in this audit;

- instruct hospitals[24] to establish procedures to return to the State agency the Federal share of any overpayments identified in their LIP cost-limit calculations;

- establish procedures to ensure that it returns to the Federal Government the Federal share of overpayments reported by hospitals;

- update the cost-limit calculation template for hospitals to include a section to report Medicaid payments (other than DSH and LIP) that are not related to specific claims and the dual-eligible patient portion of payments for Medicare cost report settlements, direct graduate medical education, Medicare bad debts, and organ acquisition costs and review the cost-limit calculations to verify that hospitals have included these payments;

- revise its LIP instruction manual to instruct participant hospitals to perform the following steps when preparing the LIP cost-limit calculations:

    - exclude the cost of non-emergency care for undocumented aliens;

    - exclude the cost of caring for prisoners in other than an inpatient setting;

    - review section 6 costs for allowability based on the RFMD;

    - distribute low-income patient days and ancillary charges to cost centers consistent with the Medicare cost report;

    - review the calculations for clerical errors and ensure that they exclude noncompliant items; and

    - reduce calculated costs by all payments received including:

        - Medicaid payments that do not relate to specific claims;

        - the portion of Medicare cost report settlements, direct graduate medical education, bad debts, and organ acquisition cost payments that relate to Medicare dual-eligible patients; and

- improve its oversight of the LIP program by establishing policies and procedures for:

    - providing additional training to its staff members on the RFMD and STCs for the waiver;

[24] Although this report specifically cites the nonreturn of self-reported overpayments for the Hospital, the State agency's instructions go to all hospitals. Additionally, CMS's Financial Management Reviews noted that the State agency had not returned the Federal share of self-reported overpayments for multiple hospitals.

- providing training to participating hospital personnel on LIP program compliance and preparing the cost-limit calculations; and

- monitoring hospital LIP calculations to verify that they comply with the RFMD and STCs including:

  - reconciling hospital cost-limit calculations to the finalized Medicare cost reports;

  - reviewing hospital low-income data to verify that it does not include data for undocumented aliens;

  - reviewing hospital low-income data to verify that it does not include data for prisoners in other than an inpatient setting;

  - testing or verifying the accuracy and completeness of the data being used by hospitals in their LIP cost-limit calculations;

  - reviewing hospital cost-limit calculations to verify that the hospitals properly incorporate observation days and charges into the calculations, as prescribed by the RFMD;

  - reviewing organ acquisition costs to verify that hospitals use the RFMD-required methodology and to verify the accuracy of the data used in the calculations;

  - establishing electronic edits in the cost-limit calculation template to detect distribution errors in which low-income costs exceed total costs for individual cost centers; and

  - reviewing section 6 costs claimed by hospitals to verify allowability based on the RFMD.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital disagreed with most of our findings. Most significantly, the Hospital contended that we incorrectly determined that it should offset Medicare and commercial insurance payments against costs for dual-eligible patients and that removing this offset would virtually eliminate the overpayment cited in the report. In addition, the Hospital strongly urged us to remove our refund recommendations from the report, noting that the Hospital is a significant provider of care to Medicaid, underinsured, uninsured, and indigent patients in South Florida. The Hospital did not specifically address our finding that the State agency had not refunded net Hospital-reported overpayments for the audit period.

After reviewing the Hospital's comments, we maintain that the State agency made payments to the Hospital in excess of allowable costs and that the State agency should refund the Federal share of the overpayments. However, after considering the Hospital's comments, we removed from our findings $1,125,000 ($756,708 Federal share) related to the fire rescue helicopter included in section 6 costs, and we reflect this removal in this final report. For reasons more fully explained below, we maintain that Medicare and commercial insurance payments for dual-eligible patients should be offset against the related costs and that we correctly recommended refunding the overpayment. In addition, we understand the importance of the Hospital's role in providing healthcare to low-income patients in South Florida. However, our objective was to assess the allowability of LIP payments that the State agency made to the Hospital. We used criteria to evaluate the allowability of LIP payments that were negotiated and established by CMS and the State agency. In particular, the STC and RFMD establish payment requirements specific to the State agency's LIP program. If the State agency and CMS had agreed to other payment requirements specific to the Hospital because of its role in providing healthcare to low-income patients, we would have used that criteria.

Below, we have addressed each of the Hospital's specific comments on our findings. The Hospital's comments are included in their entirety as Appendix D.

OVERSTATED LOW INCOME POOL PAYMENTS

Hospital Comments

The Hospital said that we overstated by $60 million the LIP payments that the Hospital received for SFY 2011 because we relied on an outdated report. The Hospital said that the State agency had reallocated LIP payments among State hospitals for that year.

Office of Inspector General Response

We used the LIP figures that the State agency had provided to us. Upon receiving the Hospital's comments on our report, we confirmed with the State agency that we had used the correct figures.

PAYMENTS FOR DUAL-ELIGIBLE PATIENTS

Hospital Comments

The Hospital stated that it "vehemently disagrees" with our finding regarding reducing unreimbursed costs by certain payments related to dual-eligible patients. The Hospital argued that Medicare and commercial insurance payments related to dual-eligible patients should not be offset against costs because the STCs say that "the Medicaid shortfall should be calculated as Medicaid costs less 'Title XIX payments' " (and do not mention Medicare or commercial insurance payments). The Hospital took issue with our citing of the RFMD language as

authority for offsetting the Medicare and insurance payments, stating that the RFMD language is ambiguous and that the RFMD cannot supersede the STCs that authorized the RFMD.

The Hospital likened our calculation of the Medicaid shortfall for LIP to CMS's position on the Medicaid shortfall calculation for Medicaid DSH, noting that CMS has lost several lawsuits preventing it from enforcing a similar interpretation. The Hospital asserted that, when the Medicare and commercial insurance payments are properly excluded from the Medicaid shortfall calculation, the total overpayment we cited would be "almost entirely eliminated."

Office of Inspector General Response

The STCs specifically state that LIP-permissible expenditures are defined in the RFMD (STC-a, items 93 and 97, and STC-b, items 76 and 80). As stated in the report, the RFMD requires all payments from non-State payers to be offset against computed costs (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). Accordingly, the STCs and RFMD require Medicare and commercial insurance payments to be offset against costs.

CMS's approval of the cost-limit calculation template, which included dual-eligible patients in section 5 of the template, further clarifies that these payments must be offset against costs. The instructions in the payments section of the template included the following unambiguous language identifying which payments should be offset: "All payments made by or on behalf of the patients in sections 2-6 above adjusted to reflect the State Fiscal Year. Exclude only payments from State and local tax sources. Include retrospective adjustments received during the year as well as gross LIP and DSH Medicaid payments." These instructions say exactly what may be excluded—namely, payments from State and local tax sources—thus precluding the exclusion of Medicare and commercial insurance payments for dual-eligible patients.

Although the Hospital asserted that the $728 million overpayment would be nearly eliminated if we excluded Medicare and commercial insurance payments from the Medicaid shortfall calculation, the Hospital had correctly offset Medicare and commercial insurance claims payments in its cost-limit calculations. Eliminating the entire $728 million overpayment ($436 million Federal share) from the Medicaid shortfall calculation would also require inappropriately removing those payments from the cost-limit calculations. Besides, our two findings regarding dual-eligible patients totaled only about $111.6 million: (1) the Hospital did not offset the Medicare dual-eligible patients' portion of various payments not related to specific claims ($88.5 million) and (2) the Hospital incorrectly excluded certain dual-eligible patients from its calculations ($6.3 million for SFY 2011 and $16.8 million for SFY 2012). Even if we agreed with the Hospital's assertions (which we do not), removing these two findings would not come close to eliminating the entire $728 million overpayment.

Finally, the Hospital's argument regarding CMS's position on Medicaid DSH is not relevant to our report on the LIP program.

NON-QUALIFIED ALIENS COSTS

Hospital Comments

The Hospital agreed that costs of caring for undocumented aliens are not allowable for the LIP program. However, the Hospital contended that the costs we identified were not related to caring for undocumented aliens. The Hospital stated that we made that assumption because we lacked documentation.

Office of Inspector General Response

As we noted in our report, the Hospital identified these patients as undocumented aliens when assigning them to a financial class in its accounting records. Missing documentation was not an issue. We believe our finding regarding undocumented aliens is appropriate.

COSTS OF OUTPATIENT CARE FOR PRISONERS

Hospital Comments

The Hospital argued that it was not clear that the criteria we cited regarding the allowability of the costs of outpatient care provided to prisoners was applicable in the context of the LIP program. The Hospital acknowledged that CMS had stated in the context of Medicaid DSH that such costs are not allowable, but the Hospital believes that is not necessarily true for the LIP program. It noted that the STCs, in general, and the sections that we cited, in particular, did not address the costs of caring for prisoners. It argued that the CMS State Medicaid Director letter that we cited concerned the costs of caring for prisoners under the Medicaid program but not the costs of caring for prisoners that have no source of coverage.

Office of Inspector General Response

The STC sections that we cited say that LIP funds may be used for healthcare expenditures that would be within the definition of medical assistance in section 1905(a) of the Act. The CMS State Medicaid Director letter concerns the exclusion of FFP for medical care provided to inmates of a public institution under section 1905(a)(A) of the Act and clarifies that the exclusion applies only to the costs of outpatient care provided to prisoners (and not inpatient care). The State receives Federal matching funds (i.e., FFP) for its LIP expenditures. As a result, we maintain that the costs of outpatient care provided to prisoners, which is not allowable for FFP, is not an allowable LIP expenditure.

EXCLUDED ACCOUNTS

Hospital Comments

The Hospital said that it believed that the LIP cost limit did not require the inclusion of all low-income patient costs. The Hospital specifically said that it believed that it was appropriate to exclude certain patients who received no Medicaid benefit but were Medicaid eligible and for whom there was no payment shortfall (i.e., payments exceeded estimated costs). Furthermore, it speculated that we included such patients in our cost-limit calculations for the sole purpose of reducing the allowable LIP cost limit.

Office of Inspector General Response

We maintain that it is inappropriate to exclude low-income patients from certain categories from the cost-limit calculations because payments for those patients exceeded estimated costs. Excluding low-income patients distorts the amount by which the Hospital's costs exceeded payments for the applicable categories of patients. For example, approximately $23.1 million of the total $37.3 million finding on "excluded accounts" related to patients who were in the dual-eligible category. To identify the amount by which the Hospital's costs of caring for dual-eligible patients exceeded payments received, the Hospital had to include all dual-eligible patients. It is no more appropriate to exclude patients from this category than it would be to selectively exclude certain Medicaid fee-for-service or Medicaid managed-care patients for whom the Hospital estimated that the Medicaid or Medicaid MCO payments exceeded costs. We maintain that the Hospital overstated its allowable costs by $37.3 million ($21.4 million Federal share) related to improperly excluded accounts.

DISTRIBUTION OF LOW-INCOME DATA

Hospital Comments

The Hospital said that it believed that its method of allocating low-income data was permissible under the STCs and RFMD. It further contended that our allocation method was flawed and inappropriate.

Office of Inspector General Response

The Hospital did not cite in its comments a specific problem with our method for correcting the allocation of low-income data. We continue to believe that our method, which correctly allocated low-income patient data to the same cost centers where the data were included on the Medicare cost report, was correct and complied with the STC requirement that costs be calculated using methodologies from the Medicare cost report (a requirement that is reiterated in the RFMD).

ORGAN ACQUISITION COSTS

Hospital Comments

The Hospital agreed with our update of its organ acquisition cost calculations based on data from the finalized Medicare cost reports. However, the Hospital maintained that the method it had used to calculate those costs was permissible under the STCs and RFMD.

Office of Inspector General Response

The Hospital used two completely different methods for calculating organ acquisition costs during the audit period (one method for SFYs 2010 and 2011 and another for SFYs 2012 through 2014). Only the method that the Hospital used for SFYs 2012 through 2014 was consistent with the instructions in the RFMD. We adjusted the SFYs 2012 through 2014 calculations based on updated data from the finalized Medicare cost reports, as required by the RFMD. We adjusted the SFYs 2010 and 2011 calculations using the specific methodology prescribed by the RFMD and using finalized Medicare cost report data for those years. We maintain that our finding regarding organ acquisition costs is valid.

UNALLOWABLE SECTION 6 COSTS

Hospital Comments

The Hospital stated that it believed that a majority of the additional costs (i.e., section 6 costs) that we identified as unallowable were, in fact, allowable. However, it offered an argument for only one such cost: the fire rescue helicopter costs of $1,125,000. The Hospital noted that, according to 42 CFR section 440.170, transportation expenses deemed necessary to secure medical examinations and treatment for a beneficiary are allowable. The Hospital also cited Florida Statute section 409.905, which requires the State Medicaid agency to ensure that transportation is available to Medicaid recipients in need of care.

The Hospital did not make an argument in favor of the remaining identified, unallowable section 6 costs, which totaled $56,185,874 and included, among other things, costs such as a program for international patients ($25.1 million), costs of treating prisoners at a prison facility ($14.3 million), and day care costs ($6.8 million).

Office of Inspector General Response

After reviewing the information that the Hospital provided regarding the fire rescue helicopter, we agree that these costs are allowable and have removed this part of the finding. We continue to believe the remaining identified unallowable additional costs should be removed from the calculations.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with all of our findings. As its overarching concern, the State agency contended that we had not considered the interrelationship of the DSH and the LIP programs. The State agency said that because the DSH examination reports for SFYs 2012 through 2014 indicated that all $221 million in DSH payments were overpayments, we should not include those payments in the LIP cost-limit calculations. Also, the State agency said that because its preliminary analysis of rate settlements based on Medicaid cost report reviews for SFYs 2011 through 2014 indicated expected State agency recoupments of $83 million, we should reduce Medicaid payments by $83 million, resulting in an increase in the LIP cost limits.

The State agency furthermore cited its appeal of the LIP overpayments identified by CMS in a disallowance letter,[25] noting that the appeal involves LIP overpayments that overlap with the audit years. It said that it believes the overpayments are grossly overstated because they were calculated based on the same methodology as the DSH guidance that CMS was forced to withdraw (i.e., third-party payments were offset against costs). The State agency argued that our report is misleading in stating that we have identified hundreds of millions of dollars in additional overpayments (i.e., in addition to the Hospital-reported overpayments).

We agree with the State agency that the LIP and DSH programs intersect, with each program's payments being considered in the other program's calculations. We also acknowledge that the State agency's argument that the Medicaid claims payments for the period in question are still in the process of cost settlement. However, we reviewed the LIP payments based on the DSH and Medicaid claims payments as they were during our audit fieldwork, not as they might be after any possible future adjustments have been made. As we more fully discuss below, the State agency may account for any action that CMS takes on our recommendations in its final DSH settlements for the years in our audit period and in future LIP calculations.

We disagree that we were misleading in our report regarding the overpayments we identified. We were careful to point out that $132 million of the total findings resulted from $246 million in Hospital-reported overpayments offset by $114 million in Hospital-reported underpayments and that we identified an additional $554 million (i.e., "hundreds of millions in additional overpayments").

After reviewing the State agency's comments, we maintain that the State agency made payments to the Hospital in excess of allowable costs and that the State agency should refund the Federal share of the overpayments. However, after considering the comments and additional documentation provided by the State agency, we (1) reduced LIP payments by the amount that the Hospital reallocated to other hospitals, (2) reclassified the assignment of LIP payments between years, (3) revised the allocation of the LIP data based on the allocation

[25] These were self-reported overpayments calculated by the Hospital.

percentages for total days and total ancillary charges from the finalized Medicare cost reports as requested by the State agency, (4) reduced payments by the pro rata share of payments related to ancillary charges that we assigned to non-reimbursable cost centers, (5) increased organ acquisition costs to correct the organ counts that the Hospital had incorrectly input into its cost-limit calculations, and (6) removed the offset of revenues related to certain section 6 costs. Because of these six changes, we reduced the overpayment by $41,445,429 ($23,885,063 Federal share), and we reflect this reduction in this final report.

Below, we have addressed each of the State agency's specific comments on our findings. The State agency's comments are included in their entirety as Appendix E.

THE STATE AGENCY DID NOT RETURN THE FEDERAL SHARE OF THE HOSPITAL'S SELF-REPORTED OVERPAYMENTS

State Agency Comments

The State agency said that it had not returned the Federal share of the Hospital's self-reported overpayments because it disputes how CMS determined the alleged overpayments. It said that the Hospital-reported overpayments are not valid because the calculations reduced costs by some third-party payments provided to dual-eligible patients. The State agency argued that, because courts have directed CMS not to offset Medicare and commercial insurance payments for dual-eligible patients against costs in the DSH calculations, then those payments should not be offset against costs in the LIP cost-limit calculations. The State agency further argued that "CMS cannot enter into negotiations with the State of Florida asserting that LIP limits will be based on DSH limits, conduct audits where LIP limits have always been based on DSH limits, and then fail to modify the LIP limits when the courts mandate that DSH limits be changed." The State agency argued that, by removing the payments in question, the cited overpayment would be either eliminated entirely or at least substantially reduced.

The State agency also said that because it has appealed the disallowance identified in the letter in which CMS sought recovery of the hospital-reported overpayments, we should not repeat the CMS finding in our audit.

Office of Inspector General Response

Although there is an inter-relationship of the DSH and LIP programs, the rules for each program are separately defined. The LIP program rules are defined in the STCs, RFMDs, and the cost-limit calculation template. As we noted in our response to the Hospital's comments, the STCs specifically state that LIP-permissible expenditures are defined in the RFMD (STC-a, items 93 and 97, and STC-b, items 76 and 80). Also, the RFMD requires all payments from non-State payers to be offset against computed costs (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). Accordingly, the STCs and RFMD require Medicare and commercial insurance payments to be offset against costs. As we also noted in our response to the Hospital, the LIP

cost-limit calculation template approved by CMS contained unambiguous language requiring the Hospital to offset Medicare and commercial insurance payments.[26]

Based on the cited RFMD requirements and the unambiguous language in the CMS-approved cost-limit calculation template, we conclude that the Hospital was obligated to offset those payments.

It was necessary for us to include in our report the Hospital-reported overpayments identified as a disallowance in CMS's demand letter (as well as the Hospital-reported underpayments) to accurately report the net overpayment or underpayment for each year.

THE HOSPITAL OMITTED AND UNDERREPORTED MEDICAID AND MEDICARE PAYMENTS

State Agency Comments

The State agency reiterated its argument that third-party payments related to dual-eligible patients should not be offset against costs in the LIP cost-limit calculations.

The State agency said that DSH examination reports for SFYs 2012 through 2014, for which the Hospital received $221,079,238 in DSH payments, show that the Hospital was 100 percent overpaid for those years. Also, it said that the preliminary analysis of rate settlements, based on its Medicaid cost report reviews for SFYs 2011 through 2014, indicate that there will be recoupments of $82,783,027. The State agency argued that removing the DSH payments for SFYs 2012 through 2014 and adjusting for the rate settlements would increase the Hospital's cost limits by $303,862,265. In particular, the State agency said that the $221 million in DSH payments for SFYs 2012 through 2014 should be removed from our calculations to prevent collecting these payments from the Hospital twice.

The State agency also noted, as did the Hospital, that it had reallocated $60 million in LIP payments to other hospitals for SFY 2011. The State agency said that the Hospital provided interlocal agreements and documentation that the redistribution was allowable and occurred during June 2013. It contended that accounting for this redistribution would result in an increase of $60 million to the Hospital's allowable costs.

The State agency also said that we had incorrectly identified LIP payments based on the SFY in which the payments were made to the Hospital rather than the SFY to which the payments relate.

[26] Although we maintain that the LIP rules require hospitals to offset the third-party payments (regardless of the DSH-related court rulings cited by the State agency), we also note that the DC Circuit recently reversed the lower court's decision, which had vacated CMS's 2017 rule requiring Medicare and other third-party payments to be offset against costs in hospital-specific DSH-limit calculations, and thus reinstated the rule. (See *Children's Hosp. Ass'n of Tex. v. Azar*, 2019 U.S. App. LEXIS 24026 (DC Cir. 2019).)

Office of Inspector General Response

As previously stated, based on the cited RFMD requirements and the unambiguous language in the cost-limit calculation template, we disagree with the State agency's argument that the third-party payments for dual-eligible patients should not be offset against costs.

We audited the LIP cost-limit calculations based on what had actually occurred. Even though the DSH examination reports for SFYs 2012 through 2014 show 100-percent overpayment, the State agency has not refunded those DSH payments. During our audit fieldwork, the State agency confirmed the amount of DSH payments for the audit period (including the $221 million for SFYs 2012 through 2014) and did not contend that the payments should be reduced by $221 million. The STCs and the RFMD instruct the State agency to include DSH payments in the offsetting payments section of the cost-limit calculation (STC-a, and STC-b, items 94 and 77, respectively, and RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). Therefore, we do not agree that we should reduce the DSH payments by $221 million.

After refunding the LIP overpayments as recommended in our report, the State agency may work with CMS to reduce the Hospital's LIP payments included in its final DSH examination to reflect the amount of the LIP overpayment refund and prevent the Hospital from refunding the overpayments twice. Alternatively, the State agency may work with CMS to refund the identified DSH overpayments (i.e., the $221 million for SFYs 2012 through 2014) before finalizing the DSH audit and then reduce the LIP overpayment to reflect the amount of the DSH overpayment refund. Regardless of the order in which the State agency handles the refunds, we properly reported that the State agency overpaid the Hospital, including the $221 million in DSH payments for SFYs 2012 through 2014.

Regarding the State agency's preliminary analysis of rate settlements that it said projected $83 million in recoupments, we properly did not reduce payments as this is only a projected amount and the State agency had not actually recouped funds in the audit period. If the State agency makes recoupment based on rate settlements, it should reflect the amount recouped as a reduction of payments in the year in which the recoupment is made. The LIP cost-limit calculation template instructions for the payments section of the calculations say to "Include retrospective rate adjustments received during the year . . . ." Any future recoupments relating to years in our audit period would be considered retrospective adjustments, because they would be done after the SFYs to which they are applicable. Thus, it is appropriate to reflect the amount ultimately recouped as a reduction of payments for the year in which the State agency recoups the money.

After providing its comments on the draft report, the State agency provided us with the agreements detailing the Hospital's reallocation of $60 million of its SFY 2011 LIP funds to other hospitals. The agreements appear to require the Hospital to first send $60 million to the receiving hospitals and then for the receiving hospitals to return $57 million to the Hospital, resulting in a net loss to the Hospital of only $3 million. Both the Hospital and the receiving

hospitals used wire transfers to transfer the $60 million and the $57 million on the same day. Despite the stated intent of these transactions to reallocate $60 million of the Hospital's SFY 2011 LIP payments to other hospitals, the substance of the transactions appears to show that the Hospital reallocated only $3 million in LIP funds. Despite our request for clarification, the State agency did not provide any further explanation or documentation to support a reduction of $60 million in LIP payments to the Hospital. Accordingly, we have reduced the Hospital's LIP payments used in the SFY 2011 cost-limit calculation by only $3 million ($1,972,650 Federal share).

For our audit, we used the LIP payment amounts by year that the State agency provided to us. The State agency confirmed the LIP payment amounts before our issuing the draft report and later again confirmed the payments to be correct after we received the Hospital's comments on our draft report. Now that the State agency has corrected the SFY assignment of the LIP payments, we have revised the LIP payments by SFY to reflect the changes that the State agency communicated in its comments. This revision resulted in no change to the overall LIP payments or the total computable overpayment. However, because the Federal share percentage is different for each SFY, the reclassification of LIP payments between SFYs resulted in an increase in the Federal share of the overpayment of $587,776.

THE HOSPITAL CLAIMED COSTS FOR PATIENTS FOR WHOM FEDERAL FUNDING WAS NOT ALLOWABLE

State Agency Comments

The State agency contended that the DSH payments related to undocumented aliens for SFYs 2010 and 2011 should be removed from the calculation. (It had also previously said that all DSH payments for SFYs 2012 through 2014 should be removed.)

Office of Inspector General Response

Federal law prohibits payments for non-emergency care provided to undocumented aliens, and the STCs further stipulate that LIP funds cannot be used for costs associated with the provision of healthcare to undocumented aliens. The Hospital included unallowable costs for undocumented aliens in its LIP cost-limit calculation. To correct the Hospital's error, we removed costs as well as the individual claims payments for non-emergency care related to undocumented aliens. DSH payments are not patient-specific; they are lump-sum payments to hospitals to help offset hospitals' uncompensated care costs incurred in providing services to Medicaid and uninsured individuals. The STCs and the RFMD (STC-a, and STC-b, items 94 and 77, respectively and RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)) require that hospitals offset all DSH payments against allowable LIP costs. It would be inappropriate for us to reduce the amount of DSH payments included in the LIP cost-limit calculations.

THE HOSPITAL DID NOT FOLLOW SOME REIMBURSEMENT AND FUNDING METHODOLOGY DOCUMENT INSTRUCTIONS

State Agency Comments

The State agency said that, even after our reallocation of LIP data, some cost centers still had more low-income patient days or ancillary charges than total patient days or ancillary charges. The State agency said that we seemed satisfied with that because it resulted in a reduction of allowable costs. Also, it contended that allocating patient days and ancillary charges based on the Hospital's finalized Medicare cost reports would result in an increase in allowable costs and would not have cost centers for which low-income patient days or ancillary charges exceeded total patient days or ancillary charges.

In addition, the State agency said that we had allocated some ancillary charges to non-reimbursable cost centers, which resulted in a reduction of allowable costs and that we should have removed the payments associated with those charges.

Office of Inspector General Response

As part of our audit, we reallocated the Hospital's LIP data (low-income patient days and ancillary charges) because the cost-limit calculations contained numerous cost centers for which low-income costs exceeded total costs by about $226 million. There would not have been excess cost amounts if the hospital had followed the RFMD instructions and allocated the LIP data in the same way they were distributed in the Medicare cost report. We materially corrected this problem by assigning the LIP data to the same cost centers to which the data were assigned in the Medicare cost reports, reducing the excesses from about $226 million down to about $7 million (3 percent of the original total). At that point, we decided not to expend additional limited audit resources on this issue.

In its comments, the State agency suggested that we allocate low-income data based on the allocation percentages of total patient days and ancillary charges in the finalized Medicare cost reports. Recognizing that our proposed reallocation in the draft report resulted in some excesses (albeit a significantly reduced amount) of low-income costs over total costs, we agreed to reallocate the Hospital's low-income data, which did not result in any costs centers with low-income costs exceeding total costs. As a result, we reduced the overpayment by $9,785,031 ($5,391,761 Federal share).

The State agency made a valid point regarding the need to reduce payments by the portion of payments related to the ancillary charges that were allocated to non-reimbursable cost centers. Accordingly, we have reduced payments in each year's calculation with a total reduction of $4,027,966 ($2,360,650 Federal share). Our figures do not agree with the State agency's because we made minor corrections to the State agency's calculations.

We revised the "Incorrectly allocated low-income patient data" line of Appendix B to reflect the changes resulting from the revised allocation of LIP data and the reduction of payments, reducing the original total of $27,896,366 by $13,812,997 to $14,083,369 ($5,627,904 Federal share).

MISSING ORGAN ACQUISITION COSTS

State Agency Comments

The State agency said that we did not include all organ acquisition costs for low-income patients in the LIP cost-limit calculations. The State agency said that for multiple low-income patients, we included the patient days, ancillary charges, and payments but did not include the patients' organ acquisition costs. The State agency further said that we knew the organ counts were not correct. The State agency contended that properly including these costs would increase the Hospital's cost limits by $21,613,956.

Office of Inspector General Response

We did not revise the organ counts provided to us by the Hospital in calculating the organ acquisition costs, and, contrary to the State agency's assertion, neither the Hospital nor the State agency informed us at any time during our audit that the Hospital had understated the organ counts. Furthermore, we did not include any low-income patient days or ancillary charges and payments in the LIP data. Rather, the Hospital compiled these data. However, after providing its comments, the State agency has provided us with the low-income organ counts that the Hospital had compiled for the DSH reviews but incorrectly input into its LIP cost-limit calculations. Accordingly, we have revised our organ acquisition cost calculations based on the organ counts that the Hospital had used for the DSH calculation, resulting in an increase in the cost limits of $20,335,758 ($12,129,939 Federal share).

THE HOSPITAL CLAIMED UNALLOWABLE SECTION 6 COSTS

State Agency Comments

The State agency said that we should not have offset other revenue against section 6 costs because the revenue in question was derived from a State or local government tax source.

Office of Inspector General Response

The revenue that we offset related to the costs of operating the Miami Hope Clinic and the costs of providing family-based care for medically complex and fragile children. We concede the point that the contracts for the services in question provide for the Florida Department of Health to make payment to the Hospital. In accordance with the cost-limit template instructions, payments from State or local tax sources should be excluded from offsetting

payments in the cost-limit calculations. Thus, we have removed our offset of the revenue, resulting in an increase of the Hospital's allowable costs of $4,296,674 ($2,617,839 Federal share).

THE HOSPITAL MADE SEVERAL CLERICAL ERRORS

State Agency Comments

The State agency said that the data we used were incomplete and that the Hospital had offered more appropriate data to calculate a more accurate cost limit.

Office of Inspector General Response

At the exit conference in July 2018, the Hospital indicated that it was working on producing revised LIP data for all 5 years in the audit period to, among other things, include claims that it had previously omitted. We told the Hospital that 45 CFR section 95.7 specifies a 2-year filing limit that would preclude the Hospital from claiming additional costs. Under 45 CFR section 95.7, a State agency must file a claim for expenditures within 2 years after the calendar quarter in which the State agency made the expenditure. Thus, for the Hospital to revise its data to include previously omitted claims—in effect, increasing the amount claimed by the State agency—it would need to have done so within 2 years of the calendar quarter in which the State agency made its claims. The Hospital notified us of its plan to refile the data in July 2018, well beyond 2 years from the last calendar quarter of the audit period (June 30, 2014).

THE STATE AGENCY DID NOT RECONCILE THE HOSPITAL'S COST-LIMIT CALCULATIONS TO FINALIZED MEDICARE COST REPORTS

State Agency Comments

The State agency said that the organ acquisition costs that we calculated did not include costs for interns and residents and, as a result, were understated by $3,662,528.

Office of Inspector General Response

We calculated the organ acquisition costs in accordance with the RFMD instructions prepared by the State agency and approved by CMS, which require that low-income organ acquisition costs be calculated using the organ acquisition costs on schedule D-6 of the Medicare cost report (schedule D-4 after the Hospital fiscal year ended September 30, 2010). Revising the calculations as the State agency requested would not be appropriate.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered SFYs 2010 through 2014 (audit period).[27] For this period, the State agency made payments to the Hospital for the LIP program totaling $1.8 billion.

In planning and performing our audit, we limited our review of the State agency's and the Hospital's internal controls to those controls related to verifying that the LIP cost-limit calculations conformed to Federal regulations and the waiver, as further defined in the STCs and the RFMD.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable laws and regulations;
- reviewed the governing documents for the LIP program, including the STCs and the RFMD;
- obtained from the State agency a schedule of total LIP payments by provider for each SFY in our audit period;
- obtained from the State agency the cost-limit calculations that the Hospital submitted to the State agency for the audit period;
- obtained from the Hospital detailed low-income patient data supporting the cost-limit calculations and compared the supporting data with the calculations;
- reviewed the low-income patient data used in the Hospital's cost-limit calculations to identify any:
  - data for undocumented aliens and outpatient prisoners,
  - low-income data that was improperly excluded, and
  - clerical errors that the Hospital made in accumulating the data;
- compared the DSH payments on the Hospital's LIP cost-limit calculations to the DSH payments published by CMS;

[27] The audit period begins the first SFY after the period covered by CMS's Financial Management Reviews (SFYs 2007 through 2009). SFY 2014 was the most recent year for which cost-limit calculations were available when we began our audit.

- compared the LIP payments on the Hospital's LIP cost-limit calculations to the LIP payments provided to us by the State agency;

- obtained from the Hospital's Medicare administrative contractor (MAC) the Medicare payments for direct graduate medical education, bad debts, and organ acquisition costs for the audit period;

- obtained from the Hospital's MAC the Hospital's finalized Medicare cost reports for the audit period and identified the cost report settlement payments;

- calculated the portion of the payments for direct graduate medical education, bad debts, organ acquisition, and cost report settlements that related to Medicare dual-eligible patients;

- obtained from the State agency all non-claim-specific Medicaid payments made during the audit period;

- obtained from the Hospital its mapping of general ledger departments to Medicare cost report lines;

- obtained from the Hospital the low-income data for each year broken down by general ledger department;

- identified the correct distribution of low-income data for each year by moving the low-income data to the correct cost report lines based on the general ledger department assignment;

- reviewed the Hospital's section 6 costs and supporting documentation for each year;

- reviewed the Hospital's cost-limit calculations for compliance with the RFMD and the STCs;

- recalculated the Hospital's organ-acquisition costs in compliance with the instructions in the RFMD;

- recalculated the cost-limit calculations for each unallowable cost that we identified to determine the effect;

- adjusted, for each year, the cost report data to agree with the finalized Medicare cost reports provided by the Hospital's MAC; and

- discussed the results of our audit with State agency and Hospital officials.

We conducted our review in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: UNALLOWABLE COSTS INCLUDED IN COST LIMIT CALCULATIONS FOR STATE FISCAL YEARS 2010—2014

	Unallowable Costs Claimed (Total Computable)	2010	2011	2012	2013	2014	Total
(1)	**Net Hospital Self-Reported Overpayments**	**($96,773,962)**	**($17,026,556)**	**$78,364,371**	**$85,187,891**	**$82,231,269**	**$131,983,013**
	Hospital self-reported overpayments	-	-	78,364,371	85,187,891	82,231,269	245,783,531
	Hospital self-reported underpayments	(96,773,962)	(17,026,556)	-	-	-	(113,800,518)
(2)	**Omitted and Underreported Payments**	**69,629,047**	**75,771,339**	**16,592,621**	**21,051,662**	**39,605,582**	**222,650,251**
	Medicaid payments not offset	52,296,960	56,836,120	(1,337)	(470,995)	25,447,941	134,108,689
	Medicare dual-eligible patients' payments not offset	17,332,087	18,935,219	16,593,958	21,522,657	14,157,641	88,541,562
(3)	**Cost of Care for Patients Ineligible for Federal Funding**	**39,812,971**	**27,907,039**	**24,839,848**	**23,828,141**	**25,923,326**	**142,311,325**
	Cost of caring for undocumented aliens	39,159,133	24,621,462	24,111,833	23,456,559	25,387,916	136,736,903
	Cost of caring for outpatient prisoners	653,838	3,285,577	728,015	371,582	535,410	5,574,422
(4)	**Costs Not Calculated in Accordance With RFMD Instructions**	**5,200,072**	**(3,088,613)**	**29,383,023**	**23,251,869**	**13,159,434**	**67,905,785**
	Excluded low-income patient data	-	4,278,389	26,523,056	6,518,802	-	37,320,247
	Incorrectly allocated low-income patient data	(22,028,419)	(5,942,473)	2,384,706	14,272,287	25,397,268	14,083,369
	Incorrectly calculated low-income observation bed costs	3,957,003	5,293,439	1,086,493	(223,762)	1,298,469	11,411,642
	Incorrectly calculated organ acquisition costs	23,271,488	(6,717,968)	(611,232)	2,684,542	(13,536,303)	5,090,527
(5)	**Unallowable Section 6 Costs**	**12,513,084**	**10,166,320**	**8,159,383**	**8,778,050**	**12,272,363**	**51,889,200**
	Nonmedical assistance costs	12,089,109	9,682,916	4,449,843	5,039,788	5,001,317	36,262,973
	Care of prisoners at prison facilities	-	-	3,406,550	3,643,796	7,259,870	14,310,216
	Not low-income	423,975	483,404	302,990	94,466	11,176	1,316,011
(6)	**Clerical Errors in Reporting LIP Data**	**42,427,589**	**654,750**	**-**	**13,250,569**	**(8,288,568)**	**48,044,340**
(7)	**Costs Not Reconciled to Finalized Medicare Cost Reports**	**15,512,159**	**10,525,066**	**(13,006,620)**	**5,762,922**	**2,767,963**	**21,561,490**
	Total Unallowable Costs Claimed by the State Agency	**$88,320,960**	**$104,909,345**	**$144,332,626**	**$181,111,104**	**$167,671,369**	**$686,345,404**
	Total Unallowable Costs Excluding Hospital Self-Reported	**$185,094,922**	**$121,935,901**	**$65,968,255**	**$95,923,213**	**$85,440,100**	**$554,362,391**

	Unallowable Costs Claimed (Federal Share)	2010	2011	2012	2013	2014	Total
	FMAP RATES	**67.64%**	**65.76%**	**55.89%**	**57.57%**	**58.61%**	
(1)	**Net Hospital Self-Reported Overpayments**	**($65,457,908)**	**($11,195,812)**	**$43,797,847**	**$49,042,669**	**$48,195,747**	**$64,382,543**
	Hospital self-reported overpayments	-	-	43,797,847	49,042,669	48,195,747	141,036,263
	Hospital self-reported underpayments	(65,457,908)	(11,195,812)	-	-	-	(76,653,720)
(2)	**Omitted and Underreported Payments**	**47,097,088**	**49,823,444**	**9,274,031**	**12,119,442**	**23,213,821**	**141,527,826**
	Medicaid payments not offset	35,373,664	37,372,591	(747)	(271,152)	14,915,674	87,390,030
	Medicare dual-eligible patients' payments not offset	11,723,424	12,450,853	9,274,778	12,390,594	8,298,147	54,137,796
(3)	**Cost of Care for Patients Ineligible for Federal Funding**	**26,929,494**	**18,350,273**	**13,883,612**	**13,717,861**	**15,194,309**	**88,075,549**
	Cost of caring for undocumented aliens	26,487,238	16,189,842	13,476,706	13,503,941	14,880,492	84,538,219
	Cost of caring for outpatient prisoners	442,256	2,160,431	406,906	213,920	313,817	3,537,330
(4)	**Costs Not Calculated in Accordance With RFMD Instructions**	**3,517,329**	**(2,030,917)**	**16,422,906**	**13,386,100**	**7,713,072**	**39,008,490**
	Excluded low-income patient data	-	2,813,255	14,824,399	3,752,874	-	21,390,528
	Incorrectly allocated low-income patient data	(14,900,023)	(3,907,473)	1,332,872	8,216,555	14,885,973	5,627,904
	Incorrectly calculated low-income observation bed costs	2,676,517	3,480,701	607,268	(128,820)	761,065	7,396,731
	Incorrectly calculated organ acquisition costs	15,740,835	(4,417,400)	(341,633)	1,545,491	(7,933,966)	4,593,327
(5)	**Unallowable Section 6 Costs**	**8,463,850**	**6,684,864**	**4,560,483**	**5,053,523**	**7,193,139**	**31,955,859**
	Nonmedical assistance costs	8,177,073	6,367,002	2,487,128	2,901,406	2,931,397	22,864,006
	Care of prisoners at prison facilities	-	-	1,904,006	2,097,733	4,255,191	8,256,930
	Not low-income	286,777	317,862	169,349	54,384	6,551	834,923
(6)	**Clerical Errors in Reporting LIP Data**	**28,698,021**	**430,531**	**-**	**7,628,352**	**(4,858,137)**	**31,898,767**
(7)	**Costs Not Reconciled to Finalized Medicare Cost Reports**	**10,492,424**	**6,920,757**	**(7,269,725)**	**3,317,714**	**1,622,372**	**15,083,542**
	Total Unallowable Costs Claimed by the State Agency	**$59,740,298**	**$68,983,140**	**$80,669,154**	**$104,265,661**	**$98,274,323**	**$411,932,576**
	Total Unallowable Costs Excluding Hospital Self-Reported	**$125,198,206**	**$80,178,952**	**$36,871,307**	**$55,222,992**	**$50,078,576**	**$347,550,033**

APPENDIX C: FEDERAL REQUIREMENTS

SOCIAL SECURITY ACT

Social Security Act § 1903(v)

Section 1903(v)(1) prohibits payments to States "for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law."

Section 1903(v)(2) provides an exception to this rule for the cost of emergency care provided to undocumented aliens.

Social Security Act § 1905(a)

Medical assistance includes inpatient and outpatient services as well as other medical and remedial services for Medicaid beneficiaries.

Social Security Act § 1905(a)(29)(A)

States may not receive FFP for medical care for inmates except for care provided in a medical institution. The CMS Director clarified in a December 12, 1997, letter to CMS Regional Administrators that the medical institution exception is for inpatient care only; there is no exception for outpatient care.

CODE OF FEDERAL REGULATIONS

45 CFR § 95.7

CMS will reimburse a State for an expenditure only if the State files a claim for that expenditure within 2 years after the calendar quarter in which it made the expenditure.

FLORIDA MEDICAID REFORM SECTION 1115 DEMONSTRATION WAIVER

The waiver does not provide any specifics on the operation of the LIP program. It states only that the State agency will maintain the LIP program.

CMS SPECIAL TERMS AND CONDITIONS FOR THE WAIVER

STC-a, Item 94, and STC-b, Item 77

LIP funds may be used for healthcare costs within the definition of "medical assistance" per section 1905(a) of the Act.

All Medicaid payments must be used to reduce the costs of caring for Medicaid patients.

Costs funded by the LIP must be for the provision of care to low-income patients.

STC-a, Item 95, and STC-b, Item 78

The State may not use LIP funds to provide non-emergency healthcare to undocumented aliens.

STC-a, Item 97, and STC-b, Item 80

Hospitals should determine expenditures using Medicare cost report methodologies.

The State agrees that it will not receive FFP for payments to hospitals in excess of their costs.

STC-b, Item 75

The State must refund the Federal share of any overpayments made to specific hospitals. CMS may recoup overpayments through a reduction of FFP claimed against LIP payments or through disallowance.

REIMBURSEMENT AND FUNDING METHODOLOGY DOCUMENT

RFMDs a, b, and c, Section IV(A)(1), (2), and (3)

Hospitals are required to calculate the inpatient routine as well as inpatient and outpatient ancillary costs for Medicaid, Medicaid managed care, and uninsured or underinsured patients (as explained in the "Hospital Cost Portion of Calculations" part of the background, the CMS approved cost-limit calculation template added a fourth category of patient, Medicare dual-eligible patients), as follows:

- determine the total hospital costs per day by inpatient routine cost center and the total cost-to-charge ratio by ancillary cost center,

- multiply each inpatient routine cost center's low-income patient days by the cost per day for the cost center, and

- multiply each ancillary cost center's inpatient and outpatient low-income charges by the cost-to-charge ratio for the cost center.

Although this section of the RFMD does not mention Medicare dual-eligible patients, the State added this category on its CMS-approved cost-limit calculation template.

Hospitals must include observation bed-days in the total inpatient day count for purposes of calculating the total inpatient routine cost per day while including low-income observation charges in the calculation of low-income ancillary costs.

Hospitals should calculate allowable organ acquisition costs for low-income patients by:

- identifying the ratio of usable organs for low-income patients, as taken from hospital records, to total usable organs, as taken from the Medicare cost report and

- multiplying that ratio by the total organ acquisition costs from the Medicare cost report.

RFMD-a, Section IV(A)(4), and RFMDs b and c, Sections IV(A)(5) and (6)

The State may include additional hospital cost items not included in the hospital LIP inpatient routine and ancillary costs. In its CMS-approved cost-limit calculation template, the State agency included a separate section for these costs entitled "Hospital Provider Additional Medicaid Costs" (section 6 costs).

RFMD-a, Section IV(A)(5), and RFMDs b and c, Section IV(A)(7)

In calculating its LIP cost limit, a hospital should offset allowable costs with its payments and recoveries from the following:

- Medicaid MCOs;

- Medicaid behavioral health organizations;

- Medicaid enrollees;

- the uninsured;

- supplemental payments (e.g., LIP);

- graduate medical education funds received that exceeded the hospital's Medicaid graduate medical education expenditures;

- DSH payments; and

- other sources, including any related patient copayments or payments from other non-State payers.

RFMDs b and c, Section IV(A)(9)

The State agency is required to reconcile the hospital cost limits to the finalized Medicare cost report for the payment year. The reconciliation process involves recomputing the cost limits using the same methodology that hospitals use for filing the cost-limit calculations but using the inpatient routine cost per day and ancillary cost-to-charge ratios calculated using the finalized Medicare cost report for the payment year.

This same section requires the State agency to refund hospital overpayments: "If, at the end of the reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the Federal [G]overnment . . . ."

RFMD-a, Section IV(A)(7), and RFMDs b and c, Section IV (A)(9)

The State agency is required to ensure that the total costs claimed in a particular year do not exceed the costs justified in the underlying hospital cost reports for the applicable years.

Jackson HEALTH SYSTEM
PUBLIC HEALTH TRUST
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Executive Office
1611 N.W. 12th Avenue
Miami, FL 33136

www.JacksonHealth.org
305-585-4211

February 26, 2019

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW Suite 3T41
Atlanta, GA 30303

Re: OIG Draft Report No. A-04-17-04058

Dear Ms. Pilcher:

Jackson Memorial Hospital (the "Hospital") appreciates the opportunity to respond to the draft audit report entitled *Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program*, A-04-17-04058 ("Draft Report"), which reviews Florida's Low Income Pool ("LIP") Program payments to the Hospital. The LIP program provides direct payments and distributions to safety-net providers in the state, including Jackson Memorial Hospital, for providing health care services to Medicaid, underinsured, and uninsured populations.

The Hospital strongly disagrees with a number of the findings in the Draft Report. For the reasons discussed below, the Hospital disagrees with the OIG's findings that that the Hospital claimed federal reimbursement for Medicaid supplemental payments that were not in accordance with State and Federal requirements, and that federal financial participation is not allowable. The OIG's findings on this issue are largely inaccurate, are based on erroneous assumptions, and misconstrue or mischaracterize documentation provided in the course of the audit.

For example, in 2011, the OIG overstated the Hospital's LIP payments by $60 million, which negatively impacts calculations showing the Hospital as over its cost limit that year. More importantly, the OIG incorrectly determined that the calculation of the Hospital's Medicaid shortfall for Medicaid patients that also have Medicare or private insurance should include payments from Medicare or private insurance. That conclusion is contrary to the Special Terms and Conditions which governed Florida's LIP program during the pertinent years at issue. Eliminating Medicare and commercial payments as an offset in the LIP calculation eliminates virtually the entire LIP overpayment claimed by the OIG in the draft report (the Hospital estimates any remaining overpayment under $10 million), even assuming the validity of the OIG's other arguments (which the Hospital does not).

The Hospital also strongly disagrees with the OIG's recommendation that Florida refund $436 million to the Federal government, as it would result in massive recoupments from the Hospital and not serve any purpose in improving administration of the Florida waiver. The OIG, with the clear benefit of

hindsight, places blame on the State Medicaid agency and the Hospital for allegedly not having adequate procedures to identify and police what OIG now sees as clear cost limits. However, as is made clear by numerous ongoing disputes with respect to these same or similar issues, including two Financial Management reviews by the Centers for Medicare & Medicaid Services ("CMS"), and two disallowances with pending appeals before the U.S. Department of Health and Human Services Departmental Appeals Board ("DAB"), these limits were by no means clear at the time.

In retrospect, it may be easy to identify that numerous prior CMS and State Medicaid agency leadership should have more precisely defined and identified cost limits and restrictions regarding the LIP Program. However, these limits and restrictions were not precisely defined and identified in real time. Massive refunds and recoupments based on years of uncertainty will only harm the State of Florida, the citizens and Miami-Dade County, the Hospital, and, most importantly, the Medicaid and uninsured patients that rely on the Jackson Health System, of which the Hospital is a part.

Regardless, the Hospital maintains that, as is elucidated by the arguments set forth herein, when its LIP cost limits are correctly calculated, the Hospital's potential federal overpayment is less than 2% of the OIG's alleged overpayment of $436 million. Lastly, the Hospital objects to including Jackson Memorial Hospital in the title of the report, since it is clear that the OIG examined Jackson Memorial Hospital because of the substantial amount of funds paid to the Hospital as the largest safety net provider in the State and not because the OIG had any reason to believe that the Hospital's processes were any different than any other provider in the State.

1. Background

a. Jackson Memorial Hospital

The Jackson Health System is a public, non-profit, tertiary care teaching hospital and health system in Miami-Dade County, Florida, and is governed and operated by the Public Health Trust of Miami-Dade County pursuant to county ordinance and Florida law.[1] Jackson Health operates the third-largest public hospital in the United States with approximately 1,500 beds and is also the major teaching hospital for the University of Miami Miller School of Medicine and is the third-largest teaching hospital in the country. Further, Jackson Health is a safety-net hospital system in Miami-Dade County and, as such, provides care to all patients regardless of payment status or source.

Jackson Health is owned and supported by the taxpayers of Miami-Dade County. As a public hospital and health system, Jackson Health receives funding from Miami-Dade County to build the health of the community by providing a single, high standard of quality care for the residents of Miami-Dade County regardless of ability to pay for services. The funding Jackson Health receives is used to provide care for the underinsured and uninsured population in Miami-Dade County. As a public hospital, Jackson Health receives safety-net funding from Miami-Dade County on an annual basis in addition to payments from various federal and Florida government sources, including the Medicaid program.

[1] Under the authority of Chapter 73-102, Laws of Florida 1973, the Dade County Board of County Commissioners enacted an ordinance on October 1, 1973, to create the Public Health Trust of Miami-Dade County, Florida to serve as an independent governing body as an agency of Miami-Dade County responsible for the operation, governance, and maintenance of Jackson Memorial Hospital and all its related facilities and property. The Public Health Trust is an instrumentality of Miami-Dade County whose purpose is to promote, protect, maintain, and improve the health and safety of all residents and visitors of Miami-Dade County.

b. The LIP Program

In 2005, the Florida Legislature authorized the Florida Medicaid agency to seek a demonstration waiver under section 1115 of the Social Security Act to transition Florida's Medicaid program from a fee-for-service program to a capitated managed care program. The waiver authority also included the creation of the LIP program and the termination of prior supplemental payments made under regulatory upper payment limits. The waiver, including the LIP program, was approved in 2005 to begin in 2006. The Special Terms and Conditions ("STCs") were the governing agreement between the State Medicaid agency (i.e., the Agency for Health Care Administration ("AHCA")) and CMS which set forth the respective obligations under the demonstration waiver. The state submitted a Reimbursement and Funding Mechanism Document ("RFMD") relevant to LIP in June 2006. Although CMS did not formally approve this document, CMS allowed payments to begin. Discussions continued regarding the RFMD, and CMS and AHCA finally agreed on a RFMD in June 2009. The 2009 RFMD was intended to resolve issues moving both forward and backward, but clearly did not, since CMS issued two disallowances in 2016 which are currently pending before the DAB with respect to state fiscal years 2006 through 2013. This is largely the same time period as the Draft Report, which covers state fiscal years 2010 through 2014.

c. Summary of OIG Findings

The Draft Report incorrectly states that Florida paid hundreds of millions to the Hospital under the LIP program not in accordance with the waiver and applicable Federal regulations. Of the $1.8 billion in LIP payments made to the Hospital during the audit period, the OIG alleges that Florida claimed Medicaid reimbursement of $729 million ($436 million Federal share) in excess of the limits under the waiver, including $132 million ($64 million Federal share) of net Hospital-related overpayments and $597 million ($372 million Federal share) of unallowable costs. The OIG identifies a number of alleged errors and oversights on the part of the Hospital and the State which it says contributed to these unallowable costs. For example, the OIG concludes that the Hospital omitted and underreported Medicaid and Medicare payments; the Hospital did not follow some RFMD instructions; the Hospital claimed unallowable Section 6 costs; and the Hospital made several clerical errors. The Hospital disagrees.

2. OIG's findings in the Draft Report are largely inaccurate, are based on erroneous assumptions, and/or misconstrue or mischaracterize documentation provided in the course of the audit.

As discussed below, the Hospital largely disagrees with the OIG's findings in the Draft Report. In most cases, the Hospital believes that its actions were proper and consistent with the guidance provided by the State Medicaid agency and in the RFMD. There are some situations where the Hospital agrees that the recalculations suggested in the Draft Report would make the cost limit calculation more accurate. Further, the Hospital believes that these calculation issues must be assessed in the context of the ongoing discussions at the time between CMS and the State Medicaid agency. The Hospital is happy to continue to provide information to the OIG as necessary.

One important mistake in the Draft Report is the fact that the Draft Report overstates the payments made to the Hospital. Particularly for 2011, the OIG appears to have relied on an older report of payments by hospital before the State Medicaid agency reallocated LIP payments amongst the

hospitals. The Hospital's LIP payments are overstated by $60 million, which impacts calculations that show that payments were over LIP cost limits.

a. The Hospital Disagrees with the Major Portion OIG's Finding that the Hospital Omitted and Underreported Medicaid and Medicare Payments.

The OIG Draft Report points to two categories of payments where the Hospital allegedly omitted and underreported. One category consists of Medicaid payments, including LIP payments and Medicaid disproportionate share hospital ("DSH") payments. The Hospital does not disagree with the OIG regarding these omissions. The LIP limit calculation should include all payments. As noted in the Draft Report, the Hospital generally assumed that the State Medicaid agency was taking these payments into account.

The second and more substantial category concerns the treatment of payments related to dual eligible patients. The Hospital vehemently disagrees with the OIG's finding in this regard. If payments from Medicare and commercial insurance are excluded, as the Hospital believes they must be under the governing documents, the Hospital has – at most – a relatively small overpayment that equates to less than 2% of the amount alleged by the OIG.

The OIG argues that the Medicaid shortfall for Medicaid patients that also have Medicare (or private insurance) coverage should include payments from Medicare or private insurance. This is contrary to the waiver's governing agreement between CMS and AHCA, the Special Terms and Conditions. The STCs clearly state that the Medicaid shortfall should be calculated as Medicaid costs less "Title XIX payments." For example, the 2005 Special Terms and Conditions regarding LIP state that LIP can be used to compensate for "expenditures ... incurred ... by hospitals ... for uncompensated medical care costs of medical services for ... Medicaid shortfall (after all other Title XIX payments are made)".[2] The 2011 special terms and conditions similarly state that "[t]hese health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments)."[3] The OIG cites more ambiguous language in the RFMD, but this language cannot supersede the Special Terms and Conditions that authorized the RFMD.

The OIG's mischaracterization of the calculation of the Medicaid shortfall for purposes of LIP is similar to CMS' mischaracterization of the analogous Medicaid shortfall calculated in the context of the hospital-specific limit used for the Medicaid DSH program.[4] The fact that the limits are analogous is not surprising, since the LIP and DSH programs have similar purposes: to reimburse hospitals for the costs of providing care to Medicaid and uninsured patients. CMS has lost numerous federal lawsuits regarding its interpretation of the Medicaid shortfall in the Medicaid DSH context, similarly requiring that Medicare and private insurance revenues be included despite underlying authority that does not permit such

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[2] CMS, Special Terms and Conditions for the Florida Agency for Health Care Administration ¶ 94 (2005), https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/Archive/waiver/pdfs/cms_special_terms_and_conditions.pdf ("2005 STCs").

[3] CMS, Special Terms and Conditions for the Florida Agency for Health Care Administration ¶ 54 (2011), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/Managed-Medical-Assistance-MMA/fl-medicaid-reform-stc-12162011-06302014.pdf ("2011 STCs").

[4] Social Security Act § 1923(g)(1)(A), 42 U.S.C. § 1396r-4(g)(1)(A).

inclusion.[5] CMS is currently enjoined from enforcing this interpretation in the context of DSH payments.[6] The OIG's Draft Report is making the same faulty interpretation in the LIP context that CMS is enjoined from doing in the DSH context.

Thus, even assuming the validity of the OIG's other findings – which the Hospital does not – the Hospital's purported overpayment under the OIG's Draft Report is almost entirely eliminated once the dual eligibility payment issue is addressed and Medicare and commercial payments are properly excluded from the Medicaid shortfall portion of the LIP cost limit calculation.

b. Regarding Costs that OIG Says Concerned Patients For Whom Federal Funding Was Not Allowable, the Hospital Believes OIG has in Some Instances Jumped to Conclusions and in Others Guidance Was Not Clear.

The Draft Report identifies two categories of costs where the OIG indicates that federal funding was not allowed: (1) care provided to undocumented aliens and (2) outpatient care provided to prisoners. The Hospital believes that guidance regarding the treatment of these costs specifically in LIP was not clear.

With respect to undocumented aliens, the Hospital recognizes that the original Special Terms and Conditions state that "LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens."[7] However, the Hospital disagrees that the costs identified by the OIG were related to non-qualified aliens. The OIG's auditors appear to have assumed that if certain accounts were lacking documentation, then the accounts related to undocumented non-qualified aliens. The Hospital disputes that conclusion. The OIG should not be permitted to assume that patient accounts are in a not allowable class simply because of missing documentation.

With respect to outpatient care for prisoners, the Hospital does not believe applicable guidance was clear in the context of LIP. The Hospital acknowledges that in the Medicaid DSH context, CMS has stated that inmates of correctional facilities are not uninsured and thus not includable in the hospital-specific DSH limit.[8] However, it is not clear that costs associated with these patients are excluded from reimbursement under LIP. Notably, the Special Terms and Conditions do not directly address this issue, and the STC provisions cited in the Draft Report more generally indicate the scope of permissible expenditures and do not specifically exclude care to prisoners. The State Medicaid Director letter cited in the Draft Report concerns the scope of permitted coverage for Medicaid-eligible prisoners under the Medicaid program, not with respect to prisoners that have no source of coverage (including Medicaid).

c. The Hospital Disagrees with Most of Draft Report Sections Indicating that the Hospital Did Not Follow RFMD Instructions.

The Draft Report identifies four areas where the OIG indicates that the Hospital did not follow RFMD instructions: (1) including costs for all low-income patients, (2) distributing low-income data, (3)

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[5] *See Children's Hosp. Ass'n of Texas v. Azar*, 300 F. Supp. 3d 190, 205 (D.D.C. 2018); *Missouri Hosp. Ass'n v. Hargan*, No. 2:17-cv-04052, 2018 WL 814589, at *12 (W.D. Mo. Feb. 9, 2018); *Baptist Mem'l Hosp.-Golden Triangle, Inc. v. Azar*, No. 3:17-cv-491, 2018 WL 3118703, at *2 (S.D. Miss. June 25, 2018); *Tennessee Hosp. Ass'n v. Price*, No. 3:16-cv-3263, 2017 WL 2703540, at *8 (M.D. Tenn. June 21, 2017).

[6] *Children's Hosp. Ass'n of Texas v. Azar*, 300 F. Supp. 3d at 205

[7] 2005 STCs ¶ 95; 2011 STCs ¶ 55.

[8] 73 Fed. Reg. 77904, 77915 (Dec. 19, 2008); State Medicaid Director Letter #02-013, Aug. 16, 2002.

calculating organ acquisition costs, and (4) calculating low-income observation bed costs. The Hospital believes that its interpretation was permissible for many of these issues. In others, the Hospital agrees with the Draft Report.

With respect to omitted costs for certain low income patients, the LIP cost limit has never required the inclusion of all low-income patient costs. The Draft Report seems to be concerned with the omission of costs and payments related to certain patients that received no Medicaid benefits and had no payment shortfall, despite being Medicaid eligible. The Hospital believes it was permissible to treat these patients as not being Medicaid patients, given that these patients received no Medicaid benefits. The OIG wants to include these patient accounts, solely for the purpose of decreasing the LIP Limit. The Hospital disagrees.

With respect to the distribution of low-income data to calculate costs, the Draft Report is prescribing one proxy for allocating charges while the Hospital used another. The Hospital believes its method was permissible under the Special Terms and Conditions and the RFMD. Although a different proxy for allocating charges also may be acceptable, the Hospital believes that the OIG's proxy has flaws that were identified for the OIG auditor when on site and the OIG refused to correct these flaws. Thus, the Hospital believes that the calculation prescribed in the Draft Report is inappropriate.

With respect to the method for calculating organ acquisition costs, while the Hospital agrees that certain data corrections are appropriate, it similarly believes that the method it used to compute costs was permissible under the under the Special Terms and Conditions and the RFMD.

With respect to low-income observation beds, the Hospital does not object to the Draft Report findings.

d. The Hospital Disagrees with the Draft Report's Findings Regarding Unallowable Additional Costs

The Draft Report includes a number of findings regarding additional costs claimed under Section 6 of the RFMD. The scope of allowable costs under Section 6 was not clear, particularly in the earlier years of the waiver, and is the subject of current litigation between AHCA and CMS before the DAB. The Hospital believes that the majority of the costs identified in the Draft Report as not allowable were in fact allowable under the RFMD.

As one mere example, one issue before the DAB is whether amounts paid by the Hospital to the Miami-Dade County Fire-Air Ambulance Rescue unit in order to pay for transportation of uninsured patients to and from the Hospital in critical emergency situations can be included as an allowed contracted additional service under the RFMD. It appears these are the same costs challenged by the OIG in the Draft Report, which lists "Fire rescue helicopter" in a list of services that "did not qualify as 'medical assistance' as defined in section 1905(a) of the [Social Security] Act." However, the conclusion in the Draft Report is incorrect. Transportation services are clearly permitted medical assistance services under CMS regulations[9] and Florida law.[10] The Draft Report does not provide any legal basis for its finding that these services did not quality as medical assistance.

[9] See, e.g., 42 C.F.R. § 440.170 (permitting transportation "determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary").

In any event, the Hospital believes that any determination by the OIG that certain costs were unallowable prior to conclusion of the litigation between CMS and AHCA is premature. The DAB could determine that certain categories of costs were allowable.

e. The Hospital Agrees that Clerical Errors Should be Updated and that Updated Cost Report Factors Should be Used.

The Draft Report points out clerical errors that were made in the Hospital's initial submission. The Hospital agrees that clerical errors should be corrected. The Draft Report also suggests updating hospital report factors based on finalized Medicare cost reports. The Hospital has no objection to updating the calculations to use finalized cost report factors.

3. OIG Should Reverse Its Refund Recommendation Because the Hospital is Not Primarily Responsible and the Refund Will Cripple The Hospital and the Community It Serves.

Jackson Health and the Hospital is the centerpiece of the Public Health Trust and a vital safety-net provider for the Miami-Dade community. Jackson Health is required by law to provide health care services to indigent, underinsured, and uninsured residents of Miami-Dade County. Not surprisingly, Jackson Health has been one of the most significant providers of care, particularly in South Florida, to Medicaid, underinsured, uninsured and indigent patients, and is a much-needed resource in the community for patients who have challenges related to accessing health care services. Jackson Health is the largest provider of care in Florida for the homeless, uninsured, and people who simply do not pay for services. The Draft Report notes the admittedly substantial amount and high percentage of LIP payments received by the Hospital during the audit period. However, this merely reflects the substantial responsibility the Hospital shoulders and the substantial amount of care that the Hospital provides.

Because of the Hospital's high levels of Medicaid and uncompensated care, the Hospital relies heavily on the Medicaid payments provided through programs such as the Medicaid DSH and LIP programs to cover its substantial uncompensated care costs. The Hospital depends upon these payments to carry out its critical mission to provide health care to those most in need, and Jackson Health has appropriately operated based on an expectation that CMS and the State Medicaid agency would accurately calculate and distribute LIP payments.

As OIG relates in the Draft Report, CMS' Financial Management Reviews found that "the State agency did not provide hospitals with adequate oversight and guidance." The Draft Report refocuses more attention on the Hospital. However, assuming the truth of the CMS Financial Management Review, it is difficult to understand how the Hospital could be primarily to blame given the absence of adequate oversight and guidance. In this context, the Hospital is extremely concerned that the refunds recommended in the Draft Report will harm the Hospital most of all, since the State Medicaid agency will seek to recoup funds from the Hospital. This result will only harm the Hospital, the safety net in Miami-Dade County and all of South Florida, and the patients that rely on the Jackson Health System. We hope that the OIG would not consider this to be a favorable result.

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[10] Fl. Stat. § 409.905 (requiring State Medicaid agency to "ensure that appropriate transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for medically necessary and Medicaid-compensable services").

The Hospital respectfully and strongly suggests that the OIG remove the refund recommendations from its report. There was simply no way that the State Agency or Hospital could tell in real time that there were overpayments. The STCs and RFMD were too vague and lend themselves to competing post-implementation interpretation. This is particularly true in light of the fact that the issues surrounding the LIP have been essentially resolved – switching to DRG reimbursement and Medicaid Managed Care – completely redesigning the LIP with much clearer, hospital specific caps. Moreover, implementation of the Draft Report's recommendations would have no effect other than to level a devastating impact on the safety net that the Hospital is committed to providing.

Thank you for your time and consideration of the comments above. The Hospital would welcome the opportunity to discuss the OIG findings and Hospital concerns in greater detail before OIG finalizes the Draft Report. Please do not hesitate to contact me directly with any questions or requests for additional information.

Regards,

Mark T. Knight

Mark T. Knight
Executive Vice President and Chief Financial Officer

MTK:hv

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

June 28, 2019

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW Suite 3T41
Atlanta, GA 30303

Re: Response to DHHS, OIG Draft Report No. A-04-17-04058

Dear Ms. Pilcher:

The State of Florida appreciates the opportunity to review and respond to the Office of Inspector General ("OIG") draft report A-04-17-04058 ("Draft Report") on Medicaid overpayments issued in May of 2019. After careful review, we have concluded that conclusions of the report are misguided, that the title is extremely misleading, and that Florida assuredly has not, as alleged, paid "hundreds of millions in unallowable payments" to Jackson Memorial Hospital. While the Agency for Health Care Administration ("AHCA" or "Agency") is prepared to work with the Centers for Medicare & Medicaid Services ("CMS") and Jackson Memorial ("Jackson" or "Hospital") to resolve the issues identified, it believes that it would be reckless and irresponsible for the OIG to finalize the report in its current form.

The State's primary and overarching concern is that the OIG has used incomplete data when more appropriate data was readily available. Low Income Pool ("LIP") payments and LIP cost limits were investigated in isolation, without taking account of the intersection between LIP and Medicaid payments, including Medicaid disproportionate share hospital ("DSH") payments. The LIP cost limit depends in large part on payments received, or not received, through these other funding sources. Changes in one necessarily affect the other.

Virtually all of the OIG's calculations are in error as both DSH and Medicaid payments and costs for the years in question are not included in the LIP cost limit calculation. The Medicaid payments and costs for the years in question are still in the process of cost settlement. Thus even if the OIG is correct that Jackson made some errors in how it reported certain payments and costs for LIP purposes, the fundamental question of whether Jackson *actually* was paid in excess of its LIP cost limit depends on the incorporation of the DSH examinations and Medicaid cost settlements, a fact which is completely ignored in the draft audit.

Relatedly, the audit completely fails to take account of the ongoing administrative appeal that AHCA has pending before the Departmental Appeals Board within the Department of Health and Human Services ("DAB"). That appeal involves LIP "overpayments" that largely overlap with the years at issue in the audit, and which AHCA believes are grossly overstated because they were calculated using the same flawed methodology as the DSH guidance that CMS was

2727 Mahan Drive • Mail Stop #1
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL

forced to withdraw. Instead of recognizing AHCA's pending appeal and argument, the Draft Report leaves the misleading impression that it has identified hundreds of millions in *additional* overpayments, which is not the case.

The State recognizes that cost reporting data must be reported accurately, and it has been working diligently with Jackson to ensure that costs are correctly calculated and counted. But that obligation also applies to the OIG. In many instances, the OIG used inaccurate data when accurate, more appropriate data was readily available, or attempted to recalculate Jackson's uncompensated costs using cost apportionment methodologies that suffer from the same defects for which it criticized the Hospital.

As set forth more fully below, the State disagrees with every finding in the draft report. Finalizing it in its current form needlessly puts one of the largest public health system in the nation at risk. The threat of massive refunds and recoupments based on errors, miscalculations, faulty assumptions, and lack of care by the OIG in this investigation will only harm the State of Florida and the Medicaid and uninsured patients that rely on Jackson for life-saving care.

Issue: Finding #1 The State Agency did not return the federal share of the Hospital's self-reported overpayments.

Florida agrees that it has not returned the federal share of the hospital's self-reported overpayments. That is because Florida disputes how CMS determined the alleged overpayments.

Specifically, in calculating its LIP limits, Jackson deducted some third-party payments for services provided to Medicaid enrollees who also had Medicare or private insurance coverage. Federal courts have repeatedly rejected CMS's failure to make similar deductions in the context of DSH, which was the basis for the LIP cost-limit calculations. *See, e.g.*, Tex. Children's Hosp. v. Burwell, 76 F. Supp. 3d 224 (D.D.C.2014); Children's Hosp. of the King's Daughters v. Price, 258 F. Supp. 3d 672, 682 (E.D. Va. 2017) (vacated in part by Children's Hospital of the King's Daughters, Inc. v. Azar, 4th Cir.(Va.), July 23, 2018); N.H. Hosp. Ass'n v. Burwell, 2016 WL 1048023 (D.N.H. 2016), aff'd, 2017 WL 822094 (1st Cir. 2017); Tenn. Hosp. Ass'n v. Price, 2017 WL 2703540 (M.D. Tenn. 2017); Children's Health Care v. CMS, 2017 WL 3668758 (D. Minn. 2017). If these third party payments are not included, Jackson's overpayments will be eliminated entirely, or at least substantially reduced.

There is no doubt that the LIP limits were patterned after the DSH limits, given that CMS was negotiating the LIP limit with the State at the same time it was issuing guidance regarding the DSH limit. However, CMS has been forced by the court decisions listed above to specifically withdraw its 2010 DSH limit guidance. See https://www.medicaid.gov/medicaid/finance/dsh/index.html. A court mandate currently prohibits CMS from enforcing a 2017 rule containing the same requirements. Id. Given that the Waiver's Special Terms and Conditions require compliance with changes in federal law, the OIG's efforts to impose on the Florida LIP program CMS' discredited and disavowed DSH guidance and rule is a plain violation of court orders.

Imposing an additional disallowance based on this flawed analysis may further raise concerns under the U.S. Constitution. It is well-established that the Medicaid program, as a program implemented under Congress' spending power, "is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of [the federal government's] power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" Pennhurst State School and Hosp. v. Halderman, 451 U.S. 1, 17 (1981).

The contract analogy, if anything, is even stronger in the context of a Section 1115 waiver, where the Federal and State governments negotiate the terms. Accordingly, if the Federal government "intends to impose a condition on the grant of federal moneys, it must do so unambiguously." Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 583 (2012) (quoting Pennhurst, 451 U.S. at 17). CMS cannot enter into negotiations with the State of Florida asserting that LIP limits will be based on DSH limits, conduct audits where LIP limits have always been based on DSH limits, and then fail to modify the LIP limits when the courts mandate that the DSH limits be changed. This is an unconstitutional ambush.

As the audit notes, in November 2016, CMS issued a disallowance letter seeking recovery of the federal share of LIP self-reported overpayments, including the federal share of alleged overpayments to Jackson Memorial for 2012 and 2013. Florida has appealed the disallowance to the DAB, DAB Docket No. A-17-64, on the ground that the calculation should not have included offsetting payments from third-parties. That case is still currently pending before the DAB.

The pending CMS disallowance and amount at issue before the DAB encompasses the entire first finding in the OIG audit; the finding therefore should **not** be repeated in the audit finding.

Issue: Finding #2 The Hospital omitted and underreported Medicaid and Medicare payments.

The audit takes the position that Jackson incorrectly omitted and underreported Medicare payments in its LIP cost-limit calculations.

Yet again, this involves the same issue that Florida is currently litigating before the DAB in Docket No. A-17-64. In addition, Jackson has brought suit against HHS and CMS in the Southern District of Florida, Case No. 1:19-cv-21206, seeking to enjoin application of a policy that would require it to count these revenues as an offset in the LIP cost-limit calculation, in accordance with the cases that have struck down a similar policy in the context of DSH payments. The audit should **not** include this calculation and the audit amounts that are in dispute.

Additionally, the OIG's review of the LIP cost-limits for the period indicates that the Hospital did not include the DSH payment received during SFY 2010 as noted in the final DSH examination report submitted to CMS. The DSH examination reports submitted to CMS for SFYs 2012-2014, however, show the Hospital as 100% overpaid for DSH payment purposes. As a result, those DSH payments should be removed from the LIP cost-limit in order to prevent the collection of these payments from the Hospital twice. Removing these payments for SFYs 2012-2014 results in an increase to allowable cost for the period of $221,079,238. While the results of the finalized DSH audits submitted to CMS showing these overpayments were available for the OIG to include in their report, the OIG chose not to.

Furthermore, while Medicaid cost report reviews for the cost report years included in the period are not complete, a preliminary analysis of rate settlements for SFYs 2011-2014 reflects agency recoupments, and therefore an increase in the LIP cost-limits of $82,783,027. Had the OIG inquired about the current status of Medicaid cost reports in question, preliminary data could have been supplied but the OIG failed to investigate this area and its impact on the Hospital's overall uncompensated cost.

Removing DSH payments and adjusting for rate settlements will immediately increase the LIP cost-limit by $303,862,265, which reduces the total Federal overpayment to $261,040,873.

The OIG also disallowed a claimed redistribution of LIP payments from the Hospital to other providers for SFY 2011 due to a lack of supporting documentation. Upon request, the Hospital was able to provide interlocal agreements to the Agency, as well as documentation that the redistribution was allowable and occurred during June 2013. Furthermore, review of agency records shows this redistribution was approved and communicated to the Hospital. The result of this redistribution is an increase in allowable cost of $60,000,000.

Finally, review of OIG support shows that the OIG adjusted LIP payments were reported based on the state year the LIP payment was submitted to the Hospital, rather than the state year for which the payment was related. The following table shows the impact of correctly reporting LIP payments based on the state year for which the payment relates to. This further serves to highlight that the OIG did not correctly report the LIP cost-limits by year.

	State Year 2010 (DY 4)	State Year 2011 (DY 5)	State Year 2012 (DY 6)	State Year 2013 (DY 7)	State Year 2014 (DY 8)
Cost Impact	($77,609,677)	$77,609,677	($32,745,755)	$1,488,603	$31,257,152

Source: 2010-2014 LIP Cost-limit, 2010-2014 DSH Examinations Submitted to CMS, 2011-2014 Preliminary Medicaid Rate Settlements, 2010-2014 LIP Payment Schedule, AHCA Table 10 2010-2011, Hospital Interlocal Agreements, Hospital Bank Records

Issue: Finding #3 The Hospital claimed costs for patients for whom federal funding was not allowable.

The OIG report identified and removed costs related to undocumented aliens originally reported in the LIP cost-limit during the period. However, the OIG failed to remove payments received related to these costs resulting in an understatement of the LIP cost-limit. The DSH payment program in Florida is designed to cover the State's large, undocumented alien population and $137,073,693 of uncompensated care costs related to undocumented aliens were specifically covered by DSH payments for the period. The OIG has included 100% of all DSH payments paid to the Hospital during SFYs 2010 and 2011 (2012-2014 DSH payments should be removed per the above **Issue: The Hospital omitted and underreported Medicaid and Medicare payments**). The reported DSH payments for these years should be decreased to account for the portion of the DSH payment applicable to undocumented aliens which for 2010 and 2011 totals to $60,946,508. The OIG should remove DSH payments related to undocumented aliens from the LIP cost-limit overpayment totals and increase total allowable cost for the period by $60,946,508. Again, the fact that the OIG did not consider the intertwining relationship between costs included in both DSH and LIP showcases that the report is fundamentally incorrect.

Source: 2010-2014 LIP Cost-limit, 2010-2014 Hospital Patient Detail Data

Issue: Finding #4 The Hospital did not follow some reimbursement and funding methodology document instructions.

The OIG report noted that the Hospital's original allocation of routine days and ancillary charges in the LIP cost-limit resulted in more low-income patient days or ancillary charges allocated to certain cost centers than there were total hospital patient days or ancillary charges. The OIG's attempt to allocate cost based on departmental mappings provided by the Hospital results in a reduction of allowable cost so the OIG was satisfied with the result. This allocation methodology, however, still

results in more low-income patient days or ancillary charges allocated to certain cost centers than there were total hospital patient days or ancillary charges. The OIG seems satisfied to leave the exact errors they were trying to correct only because their revised methodology reduced the allowable LIP cost-limit. Allocating allowable low-income patient days and ancillary charges based on the Hospital's finalized Medicare cost reports, which does not result in improper allocations as noted by the OIG, results in an increase to allowable cost for the period of $9,785,031, and is commonly accepted by Medicaid and Medicare auditors nationally.

Additionally, the OIG allocated a portion of the Hospital's ancillary charges to non-reimbursable cost centers in the LIP cost-limit. These non-reimbursable cost centers are not included in total low-income patient cost in the LIP cost-limit. Therefore, a portion of payments related to these charges should be removed from the LIP cost-limit to prevent the matching of a payment without associated cost. Removing payments related to non-reimbursable cost centers results in an increase to allowable cost for the period of $3,989,872. Both of the above issues speak to a complete and lack of understanding on behalf of the OIG as it concerns the Medicare cost report, cost apportionment methodologies, and the matching of allowable costs and payments.

Source: 2010-2014 LIP Cost-limit, 2009-2014 Finalized Medicare Cost Reports, 2010-2014 OIG Day and Charge Allocation Mappings.

Issue: Finding #4 Missing Organ Acquisition Costs.

The OIG did not include all organ acquisition costs for low-income patients in the LIP cost-limit. Review of the OIG work papers indicates that for multiple low-income patients, the OIG has included the patient's routine days, ancillary charges and payments, but has not included the patient's organ acquisition cost. A review of the Hospital's provided patient detail for the period indicates that additional low-income patient organ costs should be included in the calculation of the LIP cost-limit. Adding these missing organ counts to the organ acquisition cost calculation results in an increase to allowable cost for the period of $21,613,956. Despite the OIG's acknowledgment from the Hospital that the data as-submitted for the LIP cost-limit was incorrect regarding patient organ counts, the OIG did not investigate the potential for missing patient organ costs even as they included days, charges, and payments for those patients in the LIP cost-limit.

Source: 2010-2014 LIP Cost Limit, 2009-2014 Finalized Medicare Cost Reports, 2010-2014 Hospital Patient Detail Data

Issue: Finding #5 The Hospital claimed unallowable section 6 costs.

Instructions in Section 7 of the LIP cost-limit specifically state to report payments paid on behalf of low-income patients other than to "[e]xclude… payments from State and local tax sources." The OIG report reduced allowable Section 6 costs by payments received for Section 6 services not originally reported on the LIP cost-limits for the period. Review of the Hospital's working trial balance for the period indicates these payments are for program grants from state or local tax sources. Removing this adjustment results in an increase to allowable cost for the period of $4,296,674. As previously stated, the OIG yet again failed to adequately investigate data and supporting documentation before making their adjustments.

Source: 2010-2014 LIP Cost-limit, 2009-2014 Hospital Working Trial Balance

Issue: Finding #6 The Hospital made several clerical errors.

The underlying data used by the OIG to arrive at the dollar value overpayment was known to have been incomplete or based on erroneous data queries and could have been superseded by more appropriate data that was offered to be made available and supplied by the Hospital during the audit to calculate a more accurate LIP cost-limit to determine any possible overpayment. The OIG had the option to use this more accurate data to determine allowable cost, but intentionally opted to use the incomplete data as submitted with the Hospital's original LIP cost-limits.

Issue: Finding #7 The State agency did not reconcile the Hospital's cost-limit calculations to finalized Medicare cost reports.

The OIG report claims that the Hospital's original allocation of organ acquisition cost did not follow LIP guidelines, and re-calculated all organ acquisition cost following their interpretation of LIP guidelines and using finalized Medicare cost reports for the period. This resulted in a decrease of allowable cost for the period. The OIG's calculations, however, did not take into account intern and resident cost excluded from Medicare calculated cost totals on the finalized Medicare cost report that should be allocated to organ acquisition costs (the OIG did take these costs into consideration for routine days and ancillary charges, however). Allocating intern and resident cost to organ acquisition cost calculations results in an increase to allowable cost for the period of $3,662,528. Again, the failure of the OIG to correctly account for Medicare cost report issues belies a lack of understanding of the Hospital cost environment.

Source: 2010-2014 LIP Cost Limit, 2009-2014 Finalized Medicare Cost Reports, 2010-2014 Hospital Patient Detail Data

In December 2018, the OIG conducted an audit of CMS and issued a report titled, *The Centers for Medicare & Medicaid Services Had Not Recovered More Than a Billion Dollars in Medicaid Overpayments Identified by OIG Audits.* In her response to the draft report, Administrator Verma points out that "In instances where the states do not agree to refund the overpayments, CMS works with state officials to obtain documentation to make a determination on the allowability of the audit findings."

The State again suggests that the burden of obtaining documentation and accurate data to determine allowability must lie with the OIG in the first instance, particularly when the allegations are so clearly erroneous and inflammatory. If the OIG appreciated the intimate relationship between LIP and DSH in the Draft Report and took the time to gather accurate data, then CMS would not have to go through the costly and labor-intensive steps of re-plowing ground where the OIG already performed an audit in order to determine if the amounts claimed by the OIG were even allowable. The net result is an erroneous Draft Report that must be corrected or completely thrown out.

Sincerely,

Mary C. Mayhew
Secretary

Florida Agency for Health Care Administration, DAB No. 3031 (2021)

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Florida Agency for Health Care Administration

Docket No. A-17-64
Decision No. 3031
February 25, 2021

DECISION

The Florida Agency for Health Care Administration (Florida or State), which operates Florida's Medicaid program, challenges a January 19, 2017 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow over $97 million in federal financial participation (FFP), or the federal share of payments Florida made to hospitals under Florida's Medicaid reform waiver demonstration project pursuant to section 1115 of the Social Security Act (Act), to help defray the hospitals' uncompensated costs of providing care to low-income individuals in Florida. The challenged disallowance amount concerns payments alleged to have been made to the hospitals in excess of cost limits set in accordance with the waiver terms during demonstration years 1-7 (July 2006-June 2013).[1]

At the center of the parties' dispute is the issue of whether the hospitals were required to offset all payments received from Medicare or other payers (such as private insurance sources) on behalf of Florida Medicaid patients against costs to be reimbursed in accordance with the waiver terms. Florida denies that the hospitals were required to do so. Florida's position is based in part on federal court decisions and other developments concerning the calculation of FFP for disproportionate share hospital (DSH) payments without offsetting for certain payments. By drawing an analogy between the calculation of DSH payments and the calculation of cost limits under the waiver, Florida asserts that the payment offsets were not required. CMS, in contrast, takes the position that cost reconciliation procedures to which Florida and CMS have agreed under the waiver required offsetting of all payments that amounted to revenue to the hospitals related to otherwise-uncompensated care costs, including those omitted by Florida. We explain

below why we determine that Florida's position has no legal support. We uphold the disallowance of $97,570,183 in full.

Background

Overview of the Medicaid program

The Medicaid program, established under title XIX of the Act, is jointly funded by the federal government and states to provide medical assistance (that is, health insurance benefits) to financially needy and disabled persons. Act §§ 1902(a)(10)(A), 1902(e)-(f); 42 C.F.R. Parts 430, 435, 436. Each state that chooses to participate administers its own Medicaid program under broad federal requirements and the terms of its "plan for medical assistance" (commonly referred to as the "state plan"), which must be approved by CMS on behalf of the Secretary of Health and Human Services. Act § 1902; 42 C.F.R. Part 430, subpart B. Once the state plan is approved, a state becomes entitled to receive FFP for a percentage of its program-related expenditures. Act § 1903(a). Thus, Medicaid is "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).

In addition to authorizing federal reimbursement to states for medical assistance provided to eligible Medicaid recipients for inpatient hospital services, the federal Medicaid statute provides for state Medicaid programs to make supplemental payments to hospitals that serve disproportionately high numbers of low-income patients. Act §§ 1902(a)(13)(A)(iv), 1923(a)(1)(B). Such DSH payments supplement Medicaid rates, serve to offset a hospital's uncompensated costs of caring for the low-income population, and ensure that Medicaid recipients will continue to have access to care. *See id*. § 1923(a)-(c). The federal government reimburses (or provides FFP to) a state

for a share of its allowable DSH payments. *Id*. § 1903(a); 45 C.F.R. § 95.4 (defining "federal financial participation"). Federal reimbursement of DSH payments is subject to an annual, state-specific cap known as the "DSH allotment," and other restrictions. Act § 1923(f).

Overview of Florida's section 1115 waiver demonstration project

The Secretary of Health and Human Services, acting through CMS, has authority to waive compliance with certain statutory requirements applicable to the Medicaid program and approve experimental, pilot or demonstration projects that promote Medicaid program objectives. *See* Act § 1115. A section 1115(a) waiver demonstration project "may, for example, expand coverage to individuals not eligible for Medicaid, provide services typically not covered by Medicaid, or use innovative service delivery systems to improve care, increase efficiency, or reduce costs." *N.J. Dep't of Human Servs.*, DAB

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No. 2780, at 3 (2017). "CMS approves each section 1115(a) demonstration project subject to specific terms and conditions." *Id*.

Florida proposed a section 1115 waiver demonstration project designed to improve coverage and quality of care provided to Florida's Medicaid beneficiaries through a change in the structure of its Medicaid program from a fee-for-service model to a managed-care model. In 2005, CMS approved Florida's plan to launch the project beginning in 2006. In 2011, CMS extended the project through June 30, 2014. FL Exs. 1, 2; FL Ex. 48 (A-17-65).

Florida states that, prior to the implementation of the demonstration project, it paid annual supplemental payments (which represented the difference between standard Medicaid payment rates and what Medicare would pay, in the aggregate, for specific classes of providers for comparable services) under the Upper Payment Limit program to reimburse uncompensated costs of certain types of care provided to Medicaid beneficiaries, underinsured patients, and uninsured patients. FL Br. (A-17-65) at 2. Florida recognized that Upper Payment Limit funding is not available under a capitation model. *Id*. (citing 42 C.F.R. § 438.60). According to Florida, the waiver included a Low Income Pool (LIP) (with funding capped at $1 billion annually, as discussed in more detail below) to replace the Upper Payment Limit payments and both increase the total funding available for uncompensated costs of providing care to low-income individuals and expand the types of providers eligible to receive such funding. *Id*. at 2-3. Low-income individuals included the uninsured and the underinsured, and those participating in Medicaid for whom Medicaid payments did not fully cover the costs of care provided to those individuals.

The waiver is governed by agreements between CMS and Florida called "Special Terms and Conditions" (STCs), "which set forth in detail the nature, character, and extent of Federal involvement in the [waiver] and [Florida's] obligations to CMS during the life of the [waiver]." FL Ex. 1, at 1; FL Ex. 2, at 1.[2] The STCs in turn refer to a separate document titled "Reimbursement and Funding Methodology."[3] FL Ex. 1, at 24; FL Ex. 2, at 17. The RFMD sets out specific provisions concerning the LIP, including which expenditures may be reimbursed from the LIP and what limits apply to LIP payments to a provider ("LIP Cost Limit"). These provisions form the main subjects of the parties' dispute in this appeal.

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The waiver also included a LIP payment "reconciliation" process, which required Florida to verify the amount of LIP payments made to a provider for the fiscal period being reconciled, and then to compare that payment total to the provider's LIP Cost Limit for that period. FL Ex. 4, at 21-22. If the provider's LIP payments for the fiscal period exceeded its LIP Cost Limit, the provider was required to return the excess payment to Florida. Florida was then required to refund the federal share of that payment to CMS. *Id*.at 14-15, 18, 21; *see also* FL Ex. 5, at 4.

The disallowance determinations

Following a review of Florida's LIP payment reconciliation schedules, CMS determined that Florida had made LIP payments that exceeded the providers' LIP Cost Limits in each demonstration year from year 1 through year 8. Accordingly, by initial determination dated September 28, 2016, CMS disallowed $146,113,363 in FFP related to LIP expenditures allegedly made in excess of the allowable limits. On reconsideration, by determination dated January 19, 2017, CMS reduced some of the disallowed amounts from demonstration years 5 and 8, resulting in a revised disallowance of $97,570,183, which represents the aggregate of the remaining disallowed amounts from each of the first seven demonstration years. In the January 19, 2017 determination, CMS alleged, again, that the LIP payments exceeded permissible cost limits.

Florida timely appealed the January 19, 2017 determination disallowing $97,570,183, in accordance with section 1116(e)(2) of the Act. The parties filed briefs in accordance with the briefing schedule set by the Board and the applicable regulations in 45 C.F.R. Part 16. Also, the Safety Net Hospital Alliance of Florida (Alliance), a statewide organization of member hospital systems that collectively function as the primary "safety net" provider of hospital services to low-income Floridians,[4] sought to file briefs in appeals A-17-64 and A-17-65. The Board determined that the Alliance "has a clearly identifiable and substantial interest in the outcome" of the dispute between Florida and CMS and that the Alliance's participation in these appeals would be helpful to the Board's resolution of the appeals. Accordingly, the Board permitted the Alliance to file briefs as an intervenor. June 13, 2018 Ruling Granting Request to Submit Amicus Brief (quoting 45 C.F.R. § 16.16(b)).

Standard of review

The Board is authorized to review specified "final written decisions," including "disallowances" under title XIX of the Act (Medicaid). 45 C.F.R. Part 16, App. A, ¶ B(a)(1). The Board must sustain a disallowance "if it is supported by the evidence submitted and is consistent with the applicable statutes and regulations." *W. Va. Dep't of Health & Human Res.*, DAB No. 2185, at 20 (2008) (citing 45 C.F.R. §§ 16.14, 16.21). 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" once CMS has set out a lawful basis for its action. *N.J. Dep't of Human Servs*., DAB No. 2328, at 4-5 (2010).

Discussion

Below, in section I, we set out the LIP payment provisions that are at the center of the dispute.

In section II.A, we set out the parties' arguments before we next explain, in sections II.B, II.C, and II.D why we reject Florida's arguments on the basis of the disallowance. We find unpersuasive Florida's contention that federal court decisions and other developments concerning the calculation of FFP for DSH payments should inform our determination about whether, under the waiver, the hospitals were required to offset all payments received from Medicare or other payers on behalf of Medicaid patients against costs to be reimbursed. We reject Florida's argument that the hospitals were not required to do so because the argument has no legal support. We explain why we agree with CMS that the DSH statute, the regulations, and related CMS guidance and court decisions do not govern a determination of whether CMS properly disallowed the LIP payments in accordance with the waiver terms. We determine that the waiver required Florida to offset, in determining uncompensated costs, reimbursement received from all sources on behalf of Medicaid patients, not only Medicaid payments made by the state on their behalf. We therefore decline to remand this case to CMS for recalculation of the hospitals' LIP Cost Limits based on Florida's argument in reliance on inapplicable DSH authorities and related developments, as Florida urges us to do.

In section III, we explain why we decline to allow the alternative relief Florida seeks – reduction of the disallowance amount to eliminate altogether the LIP payment overage attributable to Jackson Memorial Hospital based on its asserted affiliation with the University of Miami Health System, whose hospitals Florida says were paid well under their LIP Cost Limits for demonstration years and 6 and 7. FL Br. at 18.

We conclude that CMS properly disallowed $97,570,183 and uphold this disallowance in full.

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I. Low Income Pool payment provisions and LIP Cost Limit

LIP payments may be used for "permissible expenditures" for services (including inpatient and outpatient hospital services) provided to Medicaid patients, the "uninsured," and the "underinsured." FL Ex. 1, at 24-25 (STCs 91, 93, 94); FL Ex. 2, at 16-18 (STCs 51, 53 and 54). "LIP permissible expenditures" – the uncompensated medical care costs for which LIP payments may be made – are further defined in the "Reimbursement and Funding Methodology, Florida Medicaid Reform Section 1115 Waiver, Low Income Pool" (FL Ex. 4, the RFMD mentioned earlier).[5] *See* FL Ex. 1, at 24 (STC 93), 25 (STC 97), and 26 (STC 100.a.); FL Ex. 2, at 17 (STC 53), 19 (STC 57); FL Ex. 4, at 6-7. "Uninsured" are "[p]ersons with no source of third party coverage"; "[u]nderinsured" are similarly defined as "[p]ersons with no source of third party coverage for services provided." FL Ex. 4, at 6; *see also* FL Ex. 5 ("Amended Special Term and Condition 105, Reconciliation draft Review Tool and Written Procedures for Reconciliation of LIP Expenditures to Allowable Provider Costs"), at 5 ("Uninsured/Underinsured" are "[p]ersons with no source of third party coverage for the services provided.").

The overarching requirement of LIP permissible hospital expenditures is that no LIP payments will be made "in excess of cost." STCs 97 and 57 state as follows:

> Hospital cost expenditures from the LIP will be paid at cost and will be further defined in the [RFMD] utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals **in excess of cost**.

FL Ex. 1, at 25 (STC 97) (emphasis added); FL Ex. 2, at 19 (STC 57); *see also* FL Ex. 1, at 25 (STC 94) and FL Ex. 2, at 18 (STC 54) (setting out a definition of "Low Income Pool Permissible Expenditures," which we will discuss in more detail later).

The RFMD broadly defines "LIP Cost Limit" as follows:

> The LIP Cost limit calculation is the total allowable expenditures less any reimbursement from Medicaid, the underinsured, or the uninsured. The reimbursement includes Medicaid claims payment for services rendered to Medicaid recipients to each provider and for hospitals, DSH payments. Payments on behalf of the underinsured and uninsured are already included

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> in the cost limit. The remaining amount is the Medicaid, underinsured and uninsured shortfall.

FL Ex. 4, at 21; *see also id*.at 3, 20, 21. LIP payments are subject to an annual, provider-specific LIP Cost Limit, which represents the maximum amount of "uncompensated" health care costs for which the provider may receive LIP payments in the fiscal year for which the limit is calculated. FL Ex. 19 (A-17-65), at 21. Therefore, in accordance with the RFMD, the LIP Cost Limit is the sum of the "Medicaid shortfall"[6] and the "uninsured and underinsured shortfall." *See* FL Ex. 4, at 14 (describing the LIP Cost Limit as the "total cost of the allowed uninsured and Medicaid shortfall costs").

The RFMD (FL Ex. 4) § IV.A includes instructions for calculating a hospital's LIP Cost Limit, which provide that total allowable hospital "expenditures" (or costs) are equal to the **sum of** –

> "Medicaid FFS [fee-for-service] costs" (allowable "routine," "ancillary," and "organ acquisition" costs as determined using the hospital's Medicare cost report and auditable hospital records) (*see* FL Ex. 4, at 7-9) AND
>
> "Medicaid managed care costs" (allowable "routine," "ancillary," and "organ acquisition" costs as determined using the hospital's Medicare cost report and auditable hospital records) (*see* FL Ex. 4, at 9-10) AND
>
> "Uninsured costs" (allowable "routine," "ancillary," and "organ acquisition" costs associated with "uninsured" patients) (*see* FL Ex. 4, at 11-13) AND
>
> "Hospital Provider Additional Medicaid Costs" (*see* FL Ex. 4, at 13)
>
> **minus**
>
> "Hospital Payments and Recoveries," as defined in RFMD § IV.A.5 (*see* FL Ex. 4, at 14).

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RFMD § IV.A.5, "Hospital Payments and Recoveries," states that the "costs computed in [the] Sections" above – clearly referring to Medicaid FFS costs, Medicaid managed care costs, "additional Medicaid costs," and uninsured costs – shall be offset against "payments and recoveries" from "all" of the following:

> Managed Care Organizations (MCO); Behavioral Health Organization's (BHOs); the Medicaid enrollees and the uninsured; supplemental payments; the amount of GME [graduate medical education] funds received that exceeded the hospital's Medicaid GME expenditures;

> any DSH payments received; and **other sources including any related patient copayments, or payments from other non-State payers**.

FL Ex. 4, at 14 (emphasis added).

In 2010, Florida submitted to CMS "Amended Special Terms and Conditions 105, Reconciliation draft Review Tool and Written Procedures for Reconciliation of LIP Expenditures to Allowable Provider Costs" (Reconciliation Procedures).[7] FL Ex. 5. Florida submitted the Reconciliation Procedures to implement an amendment to STC 105, which in part called for "retroactive adjustment and reconciliation of all previous waiver Demonstration Year cost limit calculations." *Id*. at 1. The Reconciliation Procedures include step-by-step instructions for calculating a hospital's LIP Cost Limit. *Id*. at 5-20. Like RFMD § IV.A, the Reconciliation Procedures require that a hospital's LIP Cost Limit reflect the sum of allowable routine and ancillary Medicaid FFS and Managed Care costs (FL Ex. 5, at 7-11), Medicaid's share of organ acquisition costs (*id*. at 8, 11-12), "additional Medicaid costs" (*id*. at 15-17), and allowable costs of services furnished to uninsured or underinsured persons (*id*. at 5, 12) – minus "payments and recoveries" (*id*. at 17). Table 8 in the Reconciliation Procedures specifies eight general categories of offsetting "hospital payments and recoveries" (or "Revenues"). *Id*. at 17-18. They include "Medicaid reimbursements" (Medicaid FFS payments), payments received from Medicaid managed care organizations, payments from the uninsured, DSH payments received, and "any payments" from "[o]ther sources including any related patient co-payments, or payments from other non-State payers." *Id*. at 18. The procedures state that "all payments received to help cover uncompensated care cost not included" in the first seven revenue categories "should be captured" on the line designated for "any payments" from "other sources" (line 8). *Id*. at 17.

With this detailed survey of the governing provisions, we turn next to the parties' opposing views on whether these authorities support CMS's position.

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II. CMS properly disallowed the LIP payments

A. The parties' arguments

Florida does not deny that the LIP payment reconciliations it submitted for demonstration years 1-7 show LIP overpayments of over $97 million. Florida also does not dispute that CMS may lawfully disallow FFP for LIP payments that exceeded LIP Cost Limits. Florida moreover does not disagree that the waiver terms govern a determination of whether Florida exceeded applicable cost limits.

Florida nevertheless urges the Board to remand this appeal to CMS for recalculation of the disallowed amount. Florida argues that various legal developments relating to different provisions on payments to DSH hospitals ought to be carried over to change how LIP Cost Limits are

calculated. Certain federal court decisions suggest that a DSH hospital need not account for payments received from Medicare or other third-party (non-Medicaid) payers on behalf of Medicaid-eligible patients in computing its DSH payment limit under section 1923(g) of the Act. Florida maintains that recalculating uncompensated costs for LIP Cost Limit purposes should follow the same methodology as the computation of the DSH payment limit under the court decisions. FL Br. at 6. Florida argues that LIP payments and DSH payments share a common goal – to provide "compensation for uncompensated costs incurred" by hospitals to deliver health care services to the Medicaid, underinsured, and uninsured populations – and, moreover, the LIP payment structure is similar to, and modeled after, the DSH payment structure. *Id*. Florida also asserts that it is "apparent" that both the original and extension STCs "are modeled after the definition of uncompensated costs in the DSH context." *Id*. at 11-12 (citing FL Ex. 1 (STC 94) and FL Ex. 2 (STC 54)). The STCs, says Florida, contemplate that a Medicaid shortfall is derived when Medicaid costs are deducted from Medicaid payments, which do not include payments received from Medicare or private insurers on behalf of Medicaid patients with dual coverage. *Id*.at 12. Florida contends the LIP Cost Limits should be recalculated without offsetting for Medicare and other third-party payments to be consistent with court determinations that DSH uncompensated costs exclude such payments. *Id*. at 14.

Florida states that section 1923(g) of the Act and 42 C.F.R. § 447.299(c)(16) (containing a formula for calculating the hospital-specific cap for DSH payments) required states "to subtract only Title XIX [Medicaid] revenue and revenues associated with services provided to the uninsured." *Id*. at 8. Florida thus contends that states were not required "to deduct third-party payments for services provided to Medicaid enrollees who also had Medicare or private insurance coverage." *Id*. CMS, however, did not agree with this interpretation and, in January 2010, issued guidance explaining its view of the DSH requirements. In "Additional Information on the Disproportionate Share Hospital (DSH) Reporting and Audit Requirements," CMS provided answers to frequently asked questions (DSH FAQs) and instructions for hospitals in determining their DSH payment

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limits under section 1923(g). FL Ex. 3. This guidance document, says Florida, directed hospitals and auditors to deduct, or offset, third-party revenues in determining uncompensated costs.[8] FL Br. at 8. According to Florida, the DSH FAQs were contrary to the practice many states and hospitals had followed in calculating their uncompensated costs, leading to lawsuits by hospitals that had been determined to have received DSH overpayments (under calculations consistent with 42 C.F.R. § 447.299(c) promulgated in 2008) to stop the application of the DSH FAQs. *Id*. at 7-8 (citing 73 Fed. Reg. 77,904 (Dec. 19, 2008)).

Florida now points to a number of later court decisions that rejected CMS's position that third-party payments had to be treated as revenue in computing disproportionate share hospitals' net costs. *Id*. at 8-9 (citing cases). The courts agreed with the hospitals that the

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DSH FAQs guidance exceeded statutory and regulatory requirements, and CMS therefore could not implement the guidance instructions without undergoing notice-and-comment procedures consistent with the Administrative Procedure Act. *Id*. While these cases were being litigated, CMS published a proposed rule (81 Fed. Reg. 53,980 (Aug. 15, 2016)), made final effective June 2, 2017, that amended section 447.299 to state that "costs incurred . . . [a]re defined as costs net of third-party payments, including, but not limited to, payments by Medicare and private insurance." *Id*. at 9 (quoting 82 Fed. Reg. 16,114, 16,118 (Apr. 3, 2017)). Some courts reviewing the 2017 regulation determined that it, like the DSH FAQs guidance, is substantively inconsistent with section 1923(g), i.e., that complying with the Administrative Procedure Act did not cure what the courts viewed as incorrect statutory construction. *Id*. at 9-11 (citing *Mo. Hosp. Ass'n v. Hargan*, 2018 WL 814589 (W.D. Mo. 2018) and *Children's Hosp. Ass'n of Tex*., 2018 WL 1178024 (D.D.C. 2018)[9]).

In a bulletin issued on December 31, 2018, CMS withdrew its guidance in DSH FAQs 33 and 34.[10] Thereafter, on August 13, 2019, the United States Court of Appeals for the District of Columbia Circuit reversed the district court's decision in *Children's Hospital Association of Texas v. Azar*, 300 F. Supp. 3d 190 (D.D.C. 2018). The D.C. Circuit held that the DSH payment limits established by the 2017 revision of section 447.299 are *not* inconsistent with the Medicaid statute, so that computation of DSH payment limits should include payments from third parties, including Medicare and private insurers. The court rejected the hospitals' argument that the regulation exceeded authority under the Medicaid statute and was arbitrary and capricious. *Children's Hosp. Ass'n of Texas v. Azar*, 933 F.3d 764 (D.C. Cir. 2019), *cert. denied*, 141 S. Ct. 235 (2020) (Mem). On November 4, 2019, the United States Court of Appeals for the Eighth Circuit reversed the district court's 2018 decision in *Missouri Hospital Association v. Hargan*. *Mo. Hosp. Ass'n v. Azar*, 941 F.3d 896 (8th Cir. 2019).

As noted, this entire line of authority deals with DSH payment limits, not with the LIP Cost Limits under Florida's waiver, which is the issue in the present case. Florida submits that the interpretation of the DSH payment limit computation is nevertheless germane to the interpretation of the waiver terms here, because of the similarity in wording and purpose of the statutory DSH provisions and the LIP payments. FL Br. at 5-6; Reply Br. at 1. Accordingly, Florida submits that the meaning of "uncompensated

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costs" under the waiver and DSH payment structure "should be synchronized . . . by taking into account the recent court decisions that have uniformly rejected CMS's methodology for calculating uncompensated cost amounts under DSH."[11] FL Br. at 6. Florida asks us to remand this case to CMS to recalculate the LIP Cost Limits to "remove any offsets of Medicare and private insurance revenues." *Id*. at 14.[12]

CMS, in contrast, asserts that "[t]his case does not involve statutory or regulatory construction"; that section 1115 of the Act which authorized the waiver project "does not address the issue in this case"; that the calculation of the LIP Cost Limits and reconciliations are governed by the STCs and RFMD as agreed to by CMS and Florida, not by statutes or regulations; and that the issue for the Board's resolution is whether CMS and Florida entered into the waiver agreement "with the understanding that Medicaid costs available for LIP payments would not be 'offset' by third party payments that covered these costs." CMS Response Br. at 7-8.

CMS further contends that the RFMD requires that the allowable hospital costs included in the LIP Cost Limit must be "offset" by "payments from . . . non-State payers." *Id*. at 3. CMS asserts that "Medicare and private insurance payments made on behalf of 'dual eligible beneficiaries' are 'payments from non-State payers.'" *Id*. at 5. Moreover, CMS argues that the phrase "payments . . . from non-State payers" cannot "credibl[y]" be interpreted to exclude payments from Medicare or private health insurers. *Id*. at 12. CMS submits that including such payments (meaning deducting them) in the LIP Cost Limit calculation "makes sense" because the "LIP was designed to help defray a hospital's costs for treating the uninsured, underinsured and Medicaid patients where hospital revenue received by or on behalf of these individuals was less than [the] cost of providing medical care." *Id*. at 3, 6 (citing STCs 94 and 54). CMS emphasizes that LIP payments are intended to cover "uncompensated" costs, not to "provide additional payment for costs covered by Medicare and/or private insurance," and that "[i]t is illogical for CMS to provide FFP for LIP payments for costs that are already covered by a different program." *Id*.at 6-8, 9-10, 13 ("Payments from Medicare and private insurance companies are in fact 'compensation' to the hospitals and should be treated as such.").

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Finally, CMS contends that, "[a]t the time that the STCs and RFMD were drafted (between 2006 and 2011), both CMS and Florida believed that the offsets for these third party payments were appropriate." *Id*. at 8.

B. The DSH statute, regulations, and related CMS guidance and court decisions do not govern a determination of whether CMS properly disallowed the LIP payments in accordance with the waiver terms.

As the preceding discussion explains, the parties' dispute centers on how the LIP Cost Limit should be calculated. We do not find Florida's contention that the LIP Cost Limit should be recalculated without offsetting for Medicare payments and any private insurance payments made to providers for Medicaid patients who are also covered by Medicare or have other health insurance coverage to be persuasive.

The LIP payments and DSH payments do share a common purpose – to provide supplemental funding to hospitals that provide care to low-income individuals – and to some extent are similar in how their payments are computed. Nevertheless, they stem from different authorities (CMS section 1115 waiver authority versus statutory DSH program authority) and are defined in different language used in different provisions. We do not find the account of litigation around interpreting the scope of the statutory and regulatory DSH provisions helpful here.

The validity of this disallowance determination does not turn on the language of the Medicaid statute defining DSH payments. This appeal does not involve the disallowance of FFP for DSH payments or the calculation of the hospital-specific limit on DSH payments. The LIP payments are instead a feature of the waiver demonstration project authorized under section 1115 of the Act. The LIP payment provisions are a product of an agreement between CMS and Florida on the terms (as drafted by Florida and approved by CMS) that would govern the waiver project. Those terms included provisions concerning permissible LIP expenditures and computation of the LIP Cost Limit, and they do not refer to the DSH statute or implementing DSH regulations, or the hospital-specific DSH payment limit. They do not indicate that the computation of the LIP Cost Limit is to be consistent with or synchronized with computation of the hospital-specific DSH payment limit. We therefore do not consider the district court decisions cited by Florida and the Alliance to be authoritative in this dispute in which we must interpret the waiver terms rather than statutory or regulatory DSH provisions.

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Accordingly, the question before the Board is whether the waiver terms to which CMS and Florida agreed permit Florida to calculate the LIP Cost Limit without accounting for Medicare and other third-party (non-Medicaid) insurance payments.[13] We have reviewed the waiver terms bearing in mind that the Board has long stated that a state is, in general, bound by the terms of a waiver to which it has agreed. *See Fla. Dep't of Health & Rehab. Servs.*, DAB No. 1100, at 11 (1989); *Mass. Div. of Medical Assistance*, DAB No. 1678, at 6 (1999); *see also Neb. Dep't of Soc. Servs.*, DAB No. 1389, at 4 (1993) (where the federal agency had not approved changes in methodology for determining waiver rate, the state was "bound by the terms of its approved waiver"); *N.M. Children, Youth & Families Dep't*, DAB No. 2100, at 18 (2007) ("explicit agreement" between the federal agency and the state "in the waiver terms and conditions set the term of the project as the period over which cost neutrality was to be measured").

C. The waiver terms applicable during demonstration years 1-7, as set out in the STCs and RFMD, do not permit hospitals to calculate their LIP Cost Limits without accounting for Medicare and other third-party insurance payments.

As noted, CMS and Florida agreed that the waiver would be governed by "Special Terms and Conditions," or STCs. The STCs in turn refer to a separate document, the RFMD. The RFMD sets out provisions concerning the LIP, including provisions about the expenditures that may be reimbursed from the LIP and limits on LIP payments. In this subsection, we examine the language in the STCs and the RFMD.

In reviewing the terms of the waiver, we are conscious of the nature and purpose of the LIP payment provisions. The LIP funds, as Florida acknowledges, are supplemental funds intended to defray the *uncompensated* costs incurred by hospitals that provide care to those who are uninsured or underinsured, and to Medicaid patients. FL Br. at 6; FL Br. (A-17-65) at 2. The word "uncompensated" appears in a number of STCs that discuss the purpose of the Low Income Pool or describe permissible LIP expenditures. *See, e.g.*, FL Ex. 1, at 25 (STC 94); FL Ex. 2, at 2, 16-17 (STC 51). The purpose is to pay for medical care costs for which compensation is not available. *See* FL Ex. 1, at 24 (STC 91), 25 (STCs 94, 97); FL Ex. 2, at 2, 16-17 (STC 51), 18 (STC 54). A plain, reasonable reading of the word "uncompensated," in context, would be that "uncompensated" refers to costs that exceed the reimbursements or revenue the hospitals

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take in from all funding sources to deliver care to individuals intended to benefit from the LIP funds. This overarching purpose must inform the significance of the specific provisions on how to determine the cost limits.

We begin by examining the waiver provision describing how the LIP Cost Limit is calculated. The RFMD states as follows:

> The LIP Cost Limit calculation is the total allowable expenditures less any reimbursement from Medicaid, the underinsured, or the uninsured. The reimbursement includes Medicaid claims payment for services rendered to Medicaid recipients to each provider and for hospitals, DSH payments. Payments on behalf of the underinsured and uninsured are already included in the cost limit. The remaining amount is the Medicaid, underinsured and uninsured shortfall. This amount, referred to as the LIP Cost Limit, is the maximum amount a provider is eligible to receive in a LIP distribution.

FL Ex. 4, at 21. This discussion makes clear that all Medicaid payments are to be included in the reimbursements, that is, revenues, and that all reimbursements on behalf of the underinsured or uninsured are included too, but does not explicitly address what is to be done about third-party

reimbursement for Medicaid recipients. It would be incongruous, however, to assume that a service paid for by Medicare and/or private insurance would be in any sense an "uncompensated" cost simply because the individual on whose behalf it was paid was a dually-eligible Medicaid recipient rather than, say, an underinsured patient.

The RFMD provides more detail supporting this understanding. It states that hospital expenditures or costs computed in accordance with RFMD section IV.A.5 are to be offset by "all" of the following "payments and recoveries":

> Managed Care Organizations (MCO); Behavioral Health Organization's (BHOs); the Medicaid enrollees and the uninsured; supplemental payments; the amount of GME [graduate medical education] funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; *and other sources including any related patient copayments, or payments from other non-State payers.*

FL Ex. 4, at 14 (emphasis added). The plain language of the RFMD – which Florida states "has remained the same in later iterations of the RFMD and was in effect during all time periods applicable to the disallowance" (FL Br. at 12) – thus contemplates that **all** recoveries or payments (that is, reimbursements or revenue) derived from providing care to patients benefitting from the LIP payment scheme are to be considered.

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Neither party offers extrinsic evidence of what the parties understood the words "other sources" or "payments from other non-State payers" to mean in the context of when they developed, submitted, or approved the RFMD and the Reconciliation Procedures. Florida submits that "[t]he reference to 'payments from other non-State payers' in the RFMD is not explained" in the waiver documents. *Id*.; FL Ex. 4, at 14. Florida, however, maintains that this language should not be construed to include third-party insurance payments for Medicaid patients with other sources of coverage because the phrase does not reference Medicare or private insurance, and that to construe the phrase as including third-party payments with respect to Medicaid costs (as opposed to uninsured costs) would be inconsistent with the STCs, which state that Medicaid costs are to be net only of title XIX payments. FL Br. at 12. Florida urges us to read the reference to payments from "non-State payers" in a limited way, as referring to non-State payments with respect to uninsured patients (from a tort recovery or charity, for example), asserting that such a reading is "consistent with the fact that DSH payments and LIP payments have a parallel purpose to support providers serving Medicaid and the uninsured when Medicaid payments (and payments from uninsured patients) are not adequate to cover the costs of doing so." *Id*. at 12-13.

We reject Florida's strained reading of the RFMD language in Florida's exhibit 4, page 14. Nothing in the wording remotely indicates that only a limited subset of non-state sources such as tortfeasors was contemplated. We take a direct, common-sense approach to interpret the meaning of that language, which Florida itself drafted and to which Florida and CMS have agreed. Medicare payments and any private insurance payments made on behalf of patients who have Medicare and Medicaid coverage plainly constitute payments from "other sources." Any payment from the Medicare program – a federal funding source – plainly would be payment from a "non-State" payer. Any payment made by a private insurance carrier likewise would be payment from a "non-State" payer.

Florida could have negotiated limiting "payments from other non-State payers," as it now seeks to do, to payments on behalf of uninsured or underinsured patients such as a tort recovery. The parties agreed on language that has no such express limitation. The word "non-State" in referring to payment sources, unless otherwise qualified or specifically defined in the waiver documents (which it is not), is most reasonably understood as inclusive of all payments from a federal source (Medicare) and private health insurance payment sources regardless of the status of the patient on whose behalf they are made.

Moreover, Florida's narrow focus on the words "non-State payers" in the RFMD, FL Ex. 4, at 14, appears to disregard words that immediately precede them. The RFMD states that LIP costs are to be offset by payments and recoveries from "**other sources** including any related patient copayments, or payments from other non-State payers." *Id*. (emphasis added). The reference to "other sources" is very broad and inclusive, and, in context, is most reasonably understood to mean that payments from "non-State payers" are considered to fall within the larger group of all payment sources not previously identified

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or specified. Payments from non-State payers is not a limitation on the possible sources in this language, but one of the examples of the breadth of potential sources. This supports a reading requiring all payments covering patient care costs, including those from any "non-State" source, such as Medicare or private insurance, to be offset in computing the LIP Cost Limit.

Furthermore, we see no inconsistency in the fact that the RFMD in one place (FL Ex. 4, at 21) states that the cost limit is calculated by deducting reimbursement from "Medicaid, the underinsured, or the uninsured," whereas, elsewhere (FL Ex. 4, at 14), it expressly mentions payments and recoveries from "Medicaid" and the "uninsured" (although omitting the "underinsured"[14]). The latter provision simply makes clear that the reimbursement to be captured is not limited to Medicaid and

individual patients but includes any payment on behalf of recipients or patients by referring to "other sources including any related patient copayments, or payments from other non-State payers."

Nor are we persuaded that the provision in the RFMD that "reimbursement includes Medicaid claims payment for services rendered to Medicaid recipients to each provider and for hospitals, DSH payments" somehow implies that the only reimbursement to be accounted for as to Medicaid recipients is Medicaid claims payments plus DSH payments as to hospitals. FL Ex. 4, at 21. Considering the context surrounding this statement, we read it as conveying that, with respect to Medicaid patients specifically, reimbursement to be offset *includes* not only individual claims payments for such patients, but also DSH payments made to hospitals providing care to such patients (which might not otherwise be obvious to include), but not as precluding consideration of any other reimbursement that might be made on behalf of such patients.

We now turn to the language in STCs 94 (original) and 54 (extension), under the heading "Low Income Permissible Expenditures." The parties disagree about how to read the STC language. To frame the dispute, we first quote the STCs verbatim, bolding the language CMS emphasizes and italicizing the language Florida emphasizes.

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

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> (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS[.]

FL Ex. 1, at 25 (STC 94).

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

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

FL Ex. 2, at 18 (STC 54).

Florida takes issue with CMS's emphasis on the bolded STC language, asserting that the references to "uncompensated" care and "compensation . . . not available from other payors" appear in the context of the costs of services provided to the uninsured and underinsured, not in the context of the costs of services provided to Medicaid patients. Reply Br. at 1-2. "Rather," says Florida, "both STCs refer solely to the difference between Medicaid costs and Medicaid payments" (meaning the Medicaid shortfall).[15] *Id*. at 2. Florida maintains that, while the RFMD provides that the costs of providing services to Medicaid patients and the uninsured be offset by several types of payments including payments from other non-State payers, it does not state whether the offset should be applied to all costs as CMS argues, or only to costs of providing services to the uninsured, which is all that the plain language of the STCs requires. *Id*. at 3.

We reject Florida's crabbed reading of selected STC language and reiterate two important points. Considered together, STCs 94 and 54, like the STC provisions we discussed earlier, repeatedly reinforce the basic purposes of the LIP payment scheme. Those are

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that, first, LIP payments are intended to cover uncompensated costs of providing care to LIP patients (i.e., Medicaid patients and the uninsured and underinsured), and, second, all payments made for LIP patients are to be considered in determining the LIP Cost Limit. The revised, extension STC 54 in particular makes this point clearly: that LIP payments pay for care for LIP patients "for which compensation is not available from other payors, including other Federal or State programs." Only after this language does STC 54 discuss in two additional sentences other costs that also may be included, including the Medicaid shortfall concept. The word "include," in context, is not a word of limitation.

D. Any ambiguity in the waiver terms with respect to inclusion of Medicare and other third-party insurance payments in calculating the LIP Cost Limit must be resolved against Florida.

We have explained above why CMS's reading of the applicable waiver terms is more reasonable on its face. To the extent that any ambiguity exists, we conclude that it would not be appropriate to defer to Florida's proposed reinterpretation under the circumstances here, especially given that Florida's own practice was not consistent with the interpretation it now propounds.

Board decisions discussing state plans and interpretation of state plan language are instructive here in the context of a section 1115 waiver and the terms of that waiver as drafted by Florida and agreed to by both parties. The Board has determined that, when state plan language is unambiguous, the Board "appl[ies] the clear language of the plan regardless of the interpretation urged by the state." *Ark. Dep't of Human Servs*., DAB No. 1328, at 6 (1992). If, however, the state plan provision in question is ambiguous or silent, then the Board will generally defer to the state's interpretation of the provision if it is reasonable in light of the purpose of the provision and program requirements, gives reasonable effect to the language of the plan as a whole, and, if lacking contemporary documentary evidence of intent, the state's interpretation is supported by consistent administrative practice. *W. Va. Dep't of Health & Human Res.*, DAB No. 2536, at 9 (2013) (and cited cases). "The Board [has] developed this approach [to analyzing ambiguous state plan language] for circumstances in which a state has flexibility in what state plan provisions to adopt, particularly with respect to reimbursement methodologies." *La. Dep't of Health & Hosps.*, DAB No. 2350, at 9 (2010), *aff'd, La. Dep't of Health & Hosp. v. U.S. Dep't of Health & Human Servs.*, No. 11-76-BAH-CN (M.D. La. Feb. 7, 2013), *aff'd*, 566 Fed. App'x 384 (5th Cir. 2014). "The importance of administrative practice is in part determining whether the state in fact was applying an official interpretation of a plan provision or has advanced an interpretation only as an after-the-fact attempt to justify acting inconsistently with or simply ignoring its plan." *S.D. Dep't of Soc. Servs*., DAB No. 934, at 4 (1988).

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The question, then, is whether Florida may retrospectively reinterpret the waiver terms to allow hospitals to exclude Medicare and other third-party payments for LIP patients in computing the LIP Cost Limits. As we have explained, the waiver terms are most reasonably read as contemplating that LIP payments are to be used only for uncompensated costs of care, regardless of source of compensation (that is, reimbursement for or revenue derived from providing care to LIP patients). Florida's arguments urging us to now interpret the waiver terms as permitting Florida not to offset for certain reimbursements – arguments developed long after the fact for purposes of this litigation and relying heavily on unrelated developments concerning DSH payments – raise concerns.

First, the interpretation Florida now advances is a novel one inconsistent with Florida's own prior practice. Florida, which ultimately must show that it is entitled to retain the disallowed amount, has not proffered any extrinsic evidence that, at the time the STCs and RFMD were drafted (between 2006 and 2011), the parties intended for Medicare and third-party insurance payments *not* to offset allowable hospital costs in computing the LIP Cost Limit. Nor has it proffered any evidence suggesting or indicating that, any time before CMS issued the disallowance, Florida and CMS had any discussions about permitting hospitals to exclude Medicare and other third-party insurance payments from the cost-limit calculations. Florida performed reconciliations by offsetting Medicare and private insurer payments in computing the cost limits, and did so consistently. Florida does not now argue otherwise. Its reconciliation of the LIP payments in such a way appears consistent with

CMS's position before the Board that both parties understood that such payments would be offset. *See* CMS Response Br. at 8 ("At the time that the STCs and RFMD were drafted (between 2006 [and] 2011), both CMS and Florida believed that the offsets for these third party payments were appropriate.").[16] Florida does not squarely respond to, or dispute, CMS's position.

Second, we have no argument or evidence before us indicating that Florida – which, as it says, "prepared" the RFMD and "presumably" could "change[ ]" it "subject to CMS approval" (Reply Br. at 7-8) – sought to revise any of the waiver terms concerning the computation of the cost limits. If Florida believed the waiver terms as written were not clear about how the limits were to be computed, or that those terms did not accurately capture Florida's understanding of the computation rules, then Florida presumably could have sought to revise them. Nothing in the waiver documents appears to preclude Florida from proposing prospective changes to waiver terms to expressly state that the cost limits

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will not be offset by certain payments. Florida made no effort to do so or even to communicate that the waiver terms were not clear enough or otherwise unacceptable. Instead, Florida appears to have interpreted and complied with the waiver terms based on the same understanding as CMS had until the litigation regarding the DSH payment limits presented an alternative approach that could significantly reduce or avoid its LIP overpayment liability.

Third, Florida has not shown that the hospitals themselves were confused or raised questions about what the waiver required with respect to Medicare and third-party payments for computing their LIP Cost Limits. At most, Florida now maintains that, based on its reviews of the LIP calculation worksheets submitted by the LIP providers, "it appears that providers were inconsistent in their treatment of costs and revenues associated with Medicaid eligible individuals who also had other Medicare coverage." FL Br. at 13. Furthermore, Florida acknowledges that "often hospitals that provide services to Medicaid-eligible individuals with other coverage receive no Medicaid payment at all, because the other coverage pays first, and the Medicaid rate is lower than the payment received from Medicare or private insurance," and, "[t]hus, prior to the [DSH] FAQs, many hospitals excluded costs and revenues" for such individuals "in their DSH calculations." *Id*. n.4. Whether hospitals exclude both costs and revenues for dual-eligible Medicaid recipients whose costs are covered by third-party sources in making their DSH calculations is not relevant to the meaning of the waiver provisions at issue here.

We conclude that Florida was required under the applicable waiver provisions to offset, in determining uncompensated costs, reimbursement received from all sources on behalf of Medicaid recipients, not only Medicaid payments by the State on their behalf.

III. Jackson Memorial Hospital's and University of Miami Health System hospitals' LIP-eligible costs may not be aggregated to determine whether Florida received FFP not authorized by the waiver.

Florida advances an alternative argument. It asserts that, even were the Board to disagree with Florida that the LIP Cost Limits need not be offset by Medicare and private insurance revenues for Medicaid recipients, a portion of the disallowance should be reversed for an "independent reason." FL Br. at 5. Florida maintains that it is reasonable to interpret the STCs to permit Florida to consider Jackson Memorial Hospital's LIP payments in conjunction with the University of Miami Health System hospitals' LIP payments in light of the close integration of and cooperation between Jackson Memorial and the University of Miami Health System hospitals. *Id*. at 1, 5, 15-16. Florida notes, among other things, that "payments . . . flow between the two institutions in a variety of ways." *Id*. at 16. Florida comments that "[a]ll of the questioned payments to Jackson Memorial," the primary teaching hospital for the University of Miami's Leonard M. Miller School of Medicine, "could have instead been made to the University of Miami

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hospitals, where they would have been used for many of the same purposes, given the numerous programs" (such as trauma and burn care, newborn intensive care, transplant procedures) "that the two institutions operate together." *Id*.

According to Florida, considering the hospitals' LIP-eligible costs together would eliminate Jackson Memorial's LIP overpayments from both demonstration years 6 and 7 for which CMS determined Jackson Memorial had received payments in excess of its LIP Cost Limit, because the University of Miami hospitals were paid well under their LIP Cost Limits for those two years. *Id*. at 15, 16. Based on Florida's representations, Jackson Memorial accounts for $163,552,262 in payments in excess of the LIP Cost Limit for combined demonstration years 6 and 7 – a substantial majority of the $171,379,694 total payment in excess of the LIP Cost Limit attributable to all providers for demonstration years 1-7 encompassed in the January 2017 disallowance determination (A-17-64). *Id*. at 4. Florida's opening brief sets out the following table:

Jackson/U. Miami Combined LIP Analysis[17]

Year	Jackson Memorial Over/(Under) LIP Cost Limit	University of Miami Hosp. Over/(Under) LIP Cost Limit	U. of Miami Hospital/Clinics Over/(Under) LIP Cost Limit	A.B. Leach Eye Hospital Over/(Under) LIP Cost Limit	Combined

DY 6	$78,364,371	($84,159,754)	($8,746,313)	($15,734,282)	($30,275,978)
DY 7	$85,187,891	($94,419,820)	Not calculated	Not calculated	($9,231,929)

FL Br. at 17; *see also id*. at 4 (table setting out the disallowed amounts at issue, by hospital provider, which indicates that the total amount allegedly paid to Jackson Memorial in excess of the LIP Cost Limit for demonstration years 6 and 7 is $163,552,262). Combining Jackson Memorial's LIP Cost Limit with that of the University of Miami Health System, says Florida, would eliminate the disallowance attributable to Jackson Memorial, reducing the total disallowance amount attributable to the other providers to $4,709,951[18] in FFP. *Id*. at 17; Reply Br. at 8.

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We see no language in either the STCs or the RFMD, and Florida points to none, that reasonably may be read as providing "flexibility" to treat the hospitals "on a combined basis for LIP purposes" (FL Br. at 17) based on the hospitals' integration or cooperation with one another, or for any reason. At best, Florida asserts that neither STC 97 (original) nor STC 57 (extension) (FL Ex. 1, at 25; FL Ex. 2, at 19) "specifically requires that [Florida] consider each hospital separately." FL Br. at 17. To redefine hospitals in some undefined flexible way retrospectively is not reasonable in the absence of some explicit basis in the STCs or RFMD. On the contrary, that "the RFMD . . . envisions a provider-specific cap" on LIP payments (Reply Br. at 7) contradicts Florida's claims. To allow Florida discretion to join hospitals in order to offset excess revenue at one against higher costs at another in effect would permit a hospital to exceed its specific cap and allow Florida to claim FFP in payments beyond that hospital's uncompensated costs. Florida's argument amounts to an after-the-fact attempt to eliminate a significant portion of its overall overpayment liability for excess LIP payments by having a hospital system that purportedly was paid well under the limit simply assume the overage amount attributable to a hospital that CMS says received payments well over the limit. We see no support for this attempt in the waiver terms and conditions to which Florida was bound.

Florida again states that the RFMD, which Florida drafted, "presumably can be changed by Florida, subject to CMS approval." Reply Br. at 7-8. But Florida itself reports that it proposed to CMS that Jackson Memorial's and the University of Miami hospitals' LIP Cost Limits be considered together and that CMS rejected the proposal. FL Br. at 15. We note, moreover, that, under the STCs, any change to cost sharing, LIP, and FFP (all of which would be affected by this approach) not only must be approved in advance by CMS, it may not have retroactive effect. *See* FL Ex. 1, at 3 (¶ 6) and FL Ex. 2, at 4 (¶ 6) (both setting out STC 6, "Changes Subject to the Demonstration Amendment Process," stating that changes to, among other things, cost sharing, LIP, and FFP, must be submitted as amendments to the demonstration project and approved *in advance* by CMS and that amendments to cost sharing, LIP, and FFP are "not retroactive"). Florida may not now seek to retroactively

eliminate Jackson Memorial's overage, having seen the outcome of applying the waiver under the agreed terms, by the expedient of creating a new combined provider entity retroactively for purposes of LIP calculations.

CMS notes that, in accordance with the RFMD, each hospital is to rely on its Medicare cost report to determine appropriate costs, as follows:

> The CMS 2552 costs (Medicare cost report) determined through the method prescribed for the payment year will be reconciled to the as filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare Fiscal Intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the Federal

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> government and if an underpayment is determined, the State will make the applicable claim from the Federal government.

CMS Response Br. at 14-15 (quoting FL Ex. 4 (RFMD), at 15). As CMS points out, Jackson Memorial and the University of Miami Health System submit separate Medicare cost reports, and each hospital that has received an overpayment is to properly credit it to the federal government. *Id*. at 15. CMS maintains that, even were it possible to combine the hospitals' cost reports, such an act would be inconsistent with the cost reporting process outlined in the RFMD. *Id*. Florida's reply does not respond to CMS's point that the cost reporting process as set out in the document that Florida itself prepared and agreed to by CMS would not support such a proposal.

Conclusion

The Board upholds CMS's decision to disallow $97,570,183.

/s/

Leslie A. Sussan
Board Member

/s/

Constance B. Tobias
Board Member

/s/

Susan S. Yim
Presiding Board Member

Footnotes

1. Florida filed another appeal (Board docket number A-17-65) challenging CMS's disallowance of over $63 million in FFP for payments to hospitals allegedly exceeding the waiver's cost limits during demonstration years 1-3 (July 2006–June 2009). Although appeals A-17-64 and A-17-65 involve similar types of payments and overlap in terms of the demonstration years at issue, there is no duplication in the disallowed amounts in dispute. FL Br. at 2 n.2. Moreover, the parties' briefs in appeal A-17-65 raise arguments that are different from those raised in appeal A-17-64. For these reasons, we issue separate decisions for the two appeals. However, in this decision for appeal A-17-64, we will cite or refer to the briefs and exhibits submitted for appeal A-17-65 as appropriate for relevant background information.
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2. The STCs governing the first five demonstration years are of record as Florida's exhibit 1; the STCs in effect for subsequent demonstration years are of record as Florida's exhibit 2. Florida refers to the first set of STCs as "Original STCs" and the second set as "Extension STCs." Both sets of STCs provide that "[a]ll requirements of the Medicaid Program expressed in law, regulation, and policy statement" that the waiver documents did not "expressly waive[ ]" or "identif[y] as not applicable" govern the waiver project. FL Ex. 1, at 3; FL Ex. 2, at 1.
back to note 2

3. The parties refer to this document as the "Reimbursement and Funding Methodology Document" or the "RFMD," as do we.
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4. The Alliance states that there is no uniform definition of "safety net" provider, which could be a hospital, clinic, or health center. The meaning of the term, says the Alliance, varies from state to state and from community to community, depending on numerous factors, e.g., size of the uninsured population. Safety net providers, the Alliance states, serve vulnerable populations in urban and rural communities that rely on them for access to comprehensive medical and ancillary services, and such providers, in turn, rely on payments from various sources, including Medicaid DSH payments, waiver payments such as LIP payments, and targeted grants and other supplemental funding to help defray the costs of providing uncompensated and charity care. Alliance Br. (A-17-64) at 4. According to the Alliance, all of the disallowed amount at issue in appeal A-17-64 relates to LIP payments received by Alliance members, and one such member (Jackson Memorial Hospital, the predominant safety net hospital in South Florida) accounts for over 80 percent of the disallowance in appeal A-17-64, and for over 95 percent of the disallowance in appeal A-17-65. *Id*. at 6.

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5. Florida submitted the RFMD (FL Ex. 4) to CMS in June 2006, shortly before the commencement of the waiver. CMS did not approve the 2006 RFMD as submitted, or the revised version of the RFMD submitted in 2008. In June 2009, Florida submitted a revised RFMD, which CMS approved in December 2009. The Board's decision in appeal A-17-65 discusses in more detail the revisions to the RFMD terms and intervening events between Florida's submittal of its 2006 RFMD and CMS's approval of a revised RFMD in 2009. We discuss the revisions to certain waiver language as relevant to our analysis in this appeal later in our decision.

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6. The "Medicaid shortfall" is the difference between Title XIX Medicaid costs and Medicaid payments. *See* FL Ex. 4, at 21; *see also* FL Ex. 1, at 25 (stating in STC 94 that permissible or allowable "expenditures" eligible for LIP payments include "Medicaid shortfall (after all other Title XIX payments are made)"; FL Ex. 2, at 18 (stating in STC 54 that LIP-reimbursable "health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments)").

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7. Along with the written reconciliation procedures, Florida developed and gave hospitals a "Hospital Cost Limit Calculation Form," a spreadsheet containing "locked formulas or equations that reflect the various policy decisions that have been approved by [Florida] and CMS." FL Ex. 4, at 5. The record does not include a copy of that spreadsheet but neither party has suggested that it would be material to our decision.

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8. The January 2010 guidance document's FAQs 33 and 34 read as follows:

> **33. Would days, costs, and revenue associated with patients that have both Medicaid and private insurance coverage (such as Blue Cross) also be included in the calculation of the MIUR percentage and the DSH limit in the same way States include days, costs and revenues associated with individuals dually eligible for Medicaid and Medicare?**
>
> Days, cost, and revenue associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs, and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. As Medicaid should be the payer of last resort, hospitals should also offset both Medicaid and third-party revenue associated with the Medicaid eligible day against the costs for that delay to determine any uncompensated amount.

34. The regulation states that costs for dual eligibles should be included in uncompensated care costs. Could you please explain further? Under what circumstances should we include Medicare payments?

Section 1923(g) of the Act defines hospital-specific limits on FFP for Medicaid DSH payments. Under the hospital-specific limits, a hospital's DSH payment must not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid and uninsured patients less payments received for those patients. There is no exclusion in section 1923(g)(1) for costs for, and payment made, on behalf of individuals dually eligible for Medicare and Medicaid. Hospitals that include dually-eligible days to determine DSH qualification must also include the costs attributable to dual eligibles when calculating the uncompensated costs of serving Medicaid eligible individuals. Hospitals must also take into account payment made on behalf of the individual, including all Medicare and Medicaid payments made on behalf of dual eligibles. In calculating the Medicare payment for service, the hospital would have to include the Medicare DSH adjustment and any other Medicare payments (including, but not limited to Medicaid IME and GME) with respect to that service. This would include payments for Medicare allowable bad debt attributable to dual eligibles.

FL Ex. 3, at 18.

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9. *Children's Hosp. Ass'n of Texas v. Azar*, 300 F. Supp. 3d 190 (D.D.C. 2018).

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10. On January 11, 2019, Florida submitted to the Board CMS's December 31, 2018 Medicaid.gov bulletin titled "Updated FAQs: Additional Information on the DSH Reporting and Audit Requirements," which announced that questions 33 and 34 in the 2010 DSH FAQs document were being withdrawn, as well as the revised DSH FAQs document, with the text in Frequently Asked Questions 33 and 34 stricken. The revised DSH FAQs document may be accessed at https://www.medicaid.gov/medicaid/downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf - PDF <https://www.medicaid.gov/medicaid/downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf> (last accessed on February 25, 2021).

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11. The appellate decisions in *Children's Hospital* and *Missouri Hospital Association* were issued after the parties and the intervenor filed their briefs with the Board.

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12. Florida's briefs say little specific about how recalculation of the cost limits on remand is expected to affect the cost limits or by how much the disallowance is likely to be reduced. Florida does, however, represent that, with respect to the disallowance in appeal A-17-64, based on its records, over $171 million in payments in excess of the LIP Cost Limits are attributable to 13 hospital-providers, and that over $163 million of this amount are attributable to one of those hospitals, Jackson Memorial Hospital, for demonstration years 6 and 7 (2012 and 2013). FL Br. at 4 (table), 17. According to Florida, "[i]t is not possible to determine from Jackson's LIP calculations how much Medicare and private insurance revenues were included, because these appear to

be combined generally with Medicaid revenues[,]" but Florida nevertheless does refer to certain dollar figures for Medicare and private insurance payments for Jackson Memorial for demonstration years 6 and 7. *Id*. at 14.
back to note 12

13. Despite urging the Board to remand this appeal for recalculation of the LIP Cost Limit based on its view of the DSH statute and regulations, and related district court decisions, Florida does not dispute that the waiver terms govern a determination of whether applicable cost limits were exceeded. Florida states that it "does not argue that the federal court cases striking down CMS's interpretation of uncompensated costs in the context of [DSH] payments are dispositive[,]" but rather asserts that "those cases are clearly germane to the interpretation of the STCs." Reply Br. at 1. Florida also acknowledges that "[t]he parties appear to be in agreement that the validity of the disallowance turns on the [STCs] governing" the waiver project. *Id.* As is clear in the text, we conclude that the context, history, and language of the STCs, read with the RFMD, weigh against importing an interpretation of the DSH authorities' wording.
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14. We attribute no significance to the omission of the word "underinsured." Neither party suggests that third-party payments made on behalf of underinsured patients would be treated differently than such payments on behalf of uninsured patients.
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15. "Medicaid shortfall" is not a defined legal term, though CMS has used it in policy statements and rulemaking preambles to identify one component of the hospital-specific DSH payment limit in section 1923(g) – namely, the uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid enrollees. *See Ill. Dep't of Healthcare & Family Servs*., DAB No. 2863, at 3 (2018), *reversed and remanded for further proceedings*, ___ F. Supp. 3d ___, 2020 WL 5751186 (N.D. Ill. 2020)*, appeal docketed*, No. 20-3292 (7th Cir. Nov. 25, 2020); 73 Fed. Reg. 77,904, 77,916, 77,920, 77,922 (Dec. 19, 2008). (The other component of the hospital-specific DSH limit is the cost of hospital services provided to the uninsured net of any payments by or on behalf of those individuals. DAB No. 2863, at 3.)
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16. CMS also states that, even as recently as late March 2017, when Florida filed its notice of appeal of the reconsidered disallowance determination to the Board, Florida did not assert that Medicare and private insurance payments should not be offset in computing the cost limits. CMS asserts that Florida's argument about the offsets appears to have been developed in or around 2017 for purposes of appeal to the Board even though the parties, CMS says, understood all along that the offsets were to be made to compute the cost limits. CMS Response Br. at 8. Florida does not state that CMS's statements are inaccurate or otherwise challenge this aspect of CMS's position.
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17. Florida submitted the declaration of Thomas J. Wallace, Jr., Florida's Assistant Deputy Secretary for Finance and Analytics, within the Division of Medicaid, in which Mr. Wallace attested that these figures are

based on the results of his staff's calculation of the LIP Cost Limit for Jackson Memorial and the University of Miami hospitals for 2012 and 2013. FL Ex. 7. CMS does not dispute these figures, and in any case the accuracy of the figures as represented by Florida is not an issue we need to resolve in this appeal. As we explain in the text, we reject Florida's arguments related to the proposal to combine the LIP Cost Limits to eliminate altogether the disallowance amount attributable to Jackson Memorial.

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18. Florida does not explain exactly how it arrived at $4,709,951, but we need not decide the accuracy of this figure.

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LOW INCOME POOL INTERGOVERNMENTAL TRANSFERS

The Low Income Pool (LIP) provides government support to providers for the costs of uncompensated charity care for low-income individuals who are uninsured. Uncompensated care includes charity care for the uninsured but does not include uncompensated care for insured individuals, bad debt, or Medicaid and Children's Health Insurance Program (CHIP) shortfall. For the period July 1, 2017 – June 30, 2018, the allotment for LIP is $1,508,385,773. Eligible providers are categorized in up to three groups: hospitals, Medical School Physician Practices, and Federally Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs). Hospitals may be divided into five tiers based on a combination of ownership status, statutory teaching hospital designation, children's hospital designation, and uncompensated care ratio*.

Funding for the LIP program comes from intergovernmental transfers (IGTs) and federal matching funds. IGTs are transfers of funds to the Agency for Health Care Administration (the Agency) from non-Medicaid governmental entities such as counties, hospital taxing districts, municipalities, and providers operated by state or local governments. IGT funds are then used to draw down federal matching funds and payments are made to eligible providers. Since many health care facilities benefit from IGT funds used for federal match, IGT providers are encouraged to contribute funds in order to ensure maximum payments from the LIP program.

Health care providers are encouraged to contact potential IGT providers in their area to secure IGT funding. If an eligible IGT provider is interested in participating in the LIP program, they can contact the Agency to request a Letter of Agreement (LOA). The LOA serves as the contract between the IGT provider and the Agency and authorizes the transfer IGT funds to the Agency on behalf of the designated health care provider. The Agency will invoice IGT providers to send payment once the LOA has been signed. All LOAs must be signed by October 1, 2017 and IGTs in their entirety are due to the Agency by October 31, 2017. Payments to the participating health care providers will be distributed after the IGTs are received.

If you have questions or would like to request an LOA, you may contact Ms. T. K. Feehrer at LIPProvidersReports@ahca.myflorida.com or at (850) 412-4131.

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*Uncompensated care ratio is the amount of a provider's uncompensated uninsured charity care costs expressed as a percentage of its privately insured patient care costs.

SETTLEMENT AGREEMENT

The U.S. Department of Health & Human Services ("HHS"), together with its component agency the Centers for Medicare & Medicaid Services ("CMS"), the Florida Agency for Health Care Administration ("AHCA") and the Public Health Trust of Miami-Dade County, d/b/a Jackson Health System ("Jackson Health System") (together, "the Parties") hereby agree, through their duly authorized representatives, to finally settle and fully resolve the following disputes between the Parties involving expenditures under the Low Income Pool ("LIP") established in Florida's Managed Medical Assistance Section 1115 Demonstration Project, 11-W-00206/4, for the period from July 1, 2006, through June 30, 2018 (Demonstration Years 1 through 12):

A. Disallowance FL/2016/001/MAP for **$97,570,183** federal financial participation ("FFP") relating to LIP payments made to Jackson Health System and other health care providers that were reported to CMS as being in excess of LIP-eligible costs, for the period July 1, 2006, through June 30, 2014. AHCA appealed that disallowance to the HHS Departmental Appeals Board ("Board") on March 23, 2017, and the Board issued a decision upholding the disallowance (DAB No. 3031) on February 25, 2021. AHCA appealed the DAB decision to the U.S. District Court for the Southern District of Florida, Case No. 21-cv-21616, and Jackson Health System intervened as a plaintiff. The case has been stayed while the Parties have been negotiating this global resolution.

B. Disallowance FL/2016/002/MAP for **$63,233,036** federal financial participation relating to allegedly unallowable costs included in LIP payments made to Jackson Health System, Memorial Regional, Tampa General Hospital, and Broward General, for the period July 1, 2006, through June 30, 2009. AHCA appealed that disallowance to the Board on March 23, 2017, and the Board issued a decision (DAB No. 3032) on February 25, 2021, remanding the matter to CMS to "revise and reissue a disallowance if appropriate."

C. Disallowance FL/2022/001/MAP for **$270,896,313** federal financial participation in allegedly unallowable LIP payments made to Jackson Health System for the period July 1, 2009, through June 30, 2014. The disallowance was based on Office of the Inspector General ("OIG") Audit A-04-17-04058, issued on August 30, 2019. AHCA appealed the disallowance to the Board on November 28, 2022, and the matter is now pending under DAB Docket No. A-23-16. The case has been stayed while the Parties have been negotiating this global resolution.

D. Disallowance FL/2022/002/MAP for **$150,325,421** federal financial participation relating to LIP payments to Jackson Health System and other health care providers that were reported to CMS as being in excess of LIP-eligible costs for the period July

1, 2014, through June 30, 2018. AHCA appealed the disallowance to the Board on November 28, 2022, and the matter is now pending under DAB Docket No. A-23-17. The case has been stayed while the Parties have been negotiating this global resolution.

WHEREAS the Parties are desirous of reaching a global resolution of all of these disputes (A)-(D) without further litigation; and

WHEREAS each Party's agreement to the resolution of any one of the four disputes is dependent on the Parties' agreement to resolve the remaining three disputes according to the terms set forth below, such that no part of this Agreement is severable from any other part;

NOW THEREFORE, the Parties agree to settle and compromise each and every claim of any kind, whether known or unknown, arising directly or indirectly from any of the above-listed disputes (A)-(D), on the following terms:

1. Disallowance FL/2016/001/MAP:
   a. The Parties agree that AHCA has fully repaid the **$97,570,183** disallowance including any applicable interest under 42 U.S.C. § 1396b(d)(5).
   b. Within 10 days of execution of this Settlement Agreement by all Parties, AHCA and Jackson Health System shall jointly move to voluntarily dismiss AHCA and Jackson Health System v. HHS, Case No. 21-cv-21616 (S.D. Fla.).
   c. The payment of the disallowance and the dismissal of the action shall fully and finally resolve any and all claims, known or unknown, of whatsoever kind and nature, that CMS may assert against AHCA, or that AHCA and Jackson Health System may assert against HHS or CMS, with respect to reported LIP payments in excess of LIP-eligible costs for the period July 1, 2006 through June 30, 2014.

2. Disallowance FL/2016/002/MAP:
   a. HHS and CMS agree that there shall be no further action taken on remand with respect to this disallowance, and that this Agreement resolves any and all claims, known or unknown, of whatsoever kind and nature, that CMS may assert related to unallowable costs included in LIP payments made to Jackson Health System, Memorial Regional, Tampa General Hospital, and Broward General for the period July 1, 2006 through June 30, 2009.

3. Disallowance FL/2022/001/MAP:
   a. AHCA agrees to pay **$159,828,825**, by negative adjustment on line 10A of the Quarterly Expenditure Report for the quarter ending September 30, 2023.
   b. Within 10 days of execution of this Settlement Agreement by all Parties, AHCA shall withdraw its appeal in DAB Docket No. A-23-16.

c. In consideration of this payment and AHCA's withdrawal of its appeal, HHS and CMS hereby release and discharge AHCA and Jackson Health System from any and all claims, of whatsoever kind and nature, arising out of Disallowance FL/2022/001/MAP and OIG Audit No. A-04-17-04058.

4. Disallowance FL/2022/002/MAP:

a. AHCA agrees to pay **$150,325,421** in five (5) equal annual installments by negative adjustment on Line 10B of AHCA's Quarterly Expenditure Report, beginning with the fourth quarter of Federal fiscal year 2023 and ending with the fourth quarter of Federal fiscal year 2027.

b. AHCA shall pay interest on the above amount calculated at the rate specified in 42 U.S.C. § 1396b(d)(5) through September 30, 2023. CMS shall inform AHCA of this amount no later than September 29, 2023. Thereafter, interest shall accrue on the remaining amounts at the rate of 3% simple interest per annum.

c. Within 10 days of execution of this Settlement Agreement by all Parties, AHCA shall withdraw its appeal in DAB Docket No. A-23-17.

d. In consideration of this payment and AHCA's withdrawal of its appeal, HHS and CMS hereby release and discharge any and all claims, known or unknown, of whatsoever kind and nature, that CMS may assert against AHCA with respect to reported LIP payments in excess of LIP-eligible costs for the period July 1, 2014, through June 30, 2018.

5. AHCA may prepay any of the above amounts at any time, without penalty.

6. AHCA and Jackson Health System agree that Jackson Health System shall pay AHCA $122,840,368, plus interest, in five equal annual installments towards the disallowance amounts specified above. The first installment shall be made no later than September 30, 2023, and thereafter by September 15th of the following year(s) until fully paid. Interest shall accrue at the rate of 3% simple interest per annum. Interest on the first installment shall run from June 10, 2022, until September 30, 2023. Jackson may prepay any of the above at any time without penalty.

7. If Jackson fails to make any payment on the due date of September 15th (or September 30th, with respect to 2023), AHCA may recoup funds equal to the annual installment by offset against any and all Medicaid payments due to Jackson Health System, including but not limited to payments for inpatient hospital services, outpatient hospital services, disproportionate share hospital payments, cost settlement payments, and LIP payments.

8. AHCA agrees that, provided that Jackson Health System makes the payments described in paragraph 7, it shall not seek recovery for any disallowed payment to Jackson Health System included in the four disputes (A)-(D) beyond the $122,840,368 payment described in this Agreement.

9. AHCA agrees that, if Jackson Health System fails to make the payments described in paragraph 7, it does not affect AHCA's agreement and/or obligation to make payments to HHS & CMS in the time prescribed in paragraph 4.

10. Each Party shall bear its own attorney's fees, expenses, and costs in connection with this litigation, this settlement, administrative proceedings in this case, and all related matters.

11. This Settlement Agreement is not, is in no way intended to be, and should not construed as, an admission of liability or fault on the part of the United States, its agencies, components, officials, agents, servants, or employees, or as an admission of liability or fault on the part of AHCA, its agencies, components, officials, agents, servants, or employees, or on the part of Jackson Health System. This settlement is entered into by all Parties solely for the purpose of compromising disputed claims and avoiding the expenses and risks of further litigation.

12. It is expressly acknowledged and agreed that this release and discharge shall not extend to or encompass, and the Department does not release or compromise, any of the following claims:

a. Any claims arising under criminal law;
b. Any criminal, civil, or administrative claims, rights or defenses arising under Title 26, United States Code (Internal Revenue Code).

13. This Settlement Agreement shall not constitute a precedent or argument in this or any other matter, nor shall it be used as evidence or otherwise in any pending or future civil lawsuit or administrative proceeding against or involving the Department of Health and Human Services, or its employees, representatives, or agents, or any agency or instrumentality of the United States, except as may be necessary to establish or clarify the Parties' respective rights and obligations under the Settlement Agreement, or to show estoppel against future litigation in violation of the Settlement Agreement.

14. This Settlement Agreement may be executed in several counterparts. Each such counterpart will be deemed an original, and all such counterparts, together, shall be deemed to be one document. The Settlement Agreement shall be considered executed on the latest date which this Settlement Agreement has been signed by any of the Parties to the agreement or any counsel representing any Party to the agreement. Any signature below that is transmitted by facsimile or other electronic means shall be binding and effective as the original.

15. This Settlement Agreement constitutes the entire agreement between the Parties. The Parties expressly agree and understand that this Settlement Agreement has been freely and voluntarily entered into by the Parties with the advice of counsel, who have explained the legal effect of this Settlement Agreement. The Parties further acknowledge that no warranties or representations have been made on any subject other than as set forth in this Settlement

Agreement. This Settlement Agreement may not be altered, modified or otherwise changed in any respect except by writing, duly executed by all of the Parties or their authorized representatives.

16. Each person signing this Settlement Agreement represents and warrants that he or she has full authority to execute it on the behalf of himself or herself, or on behalf of the Party or entity on whose behalf he or she signs.

17. This Settlement Agreement shall be considered a jointly drafted agreement. Any and all rules of construction to the effect that ambiguity is construed against the drafting Party shall be inapplicable in any dispute concerning the terms, meaning, or interpretation of this Agreement.

18. The Parties agree that this Settlement Agreement, including all the terms and conditions of this compromise settlement and any additional agreements relating thereto, may be made public in their entirety.

Executed on behalf of the Parties by:

Tom Wallace
Deputy Secretary for Health Care Finance & Data
On behalf of Florida Agency for Health Care Administration

Date

Mark T. Knight

Mark T. Knight
Executive Vice-President and Chief Financial Officer
On behalf of Jackson Health Systems

9/28/2023
Date

Kelsi R. Romero
Assistant United States Attorney
United States Attorney's Office, Civil Division
Miami, Florida

9/28/2023
Date

On behalf of the U.S. Department of
Health & Human Services, and the Centers
for Medicare & Medicaid Services

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA

UNITED STATES OF AMERICA and STATE OF FLORIDA *ex rel.* [redacted] and JOHN DOE, Plaintiffs,	**Filed *In Camera* and Under Seal** [redacted]
v.	
NORTH BREVARD COUNTY HOSPITAL DISTRICT d/b/a PARRISH MEDICAL CENTER; HALIFAX HOSPITAL MEDICAL CENTER; GEORGE MIKITARIAN; CHRISTOPHER McALPINE; ANUAL JACKSON, SR.; ERIC PEBURN; and JEFF FEASAL,	**DO NOT PUT ON PACER**
Defendants.	

AMENDED *QUI TAM* COMPLAINT

INTRODUCTION

1. Relators bring this action under the Federal False Claims Act, 31 U.S.C. §§ 3729 *et seq.* ("FCA"), the Florida False Claims Act, Fla. Stat. §§ 68.081 *et seq.* and the Stark Act, 42 U.S.C. § 1395nn ("Stark"). in order to recover damages and civil penalties on behalf of the United States and the State of Florida arising from false claims and fraudulent statements, records and claims made by Defendants . The allegations involve Florida's Low Income Pool ("LIP") program, the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), and Defendants' violation of Stark. The LIP Program is used to pay providers for the cost of care given to the most vulnerable patients, and the CARES Act is a $2.2 trillion economic stimulus

bill signed into law in 2020. The LIP program first was implemented by the Medicaid managed care program in 2005. LIP provides direct payments to safety-net providers with the purpose of providing health care services to Medicaid, underinsured and uninsured patients. The CARES Act aims to providing relief for individuals and businesses that have been negatively impacted by the coronavirus ("COVID") outbreak. The CARES Act does not allow physician groups to receive money from the Government for services that have already been covered by other COVID relief programs. The Stark Amendment makes it illegal for hospitals to compensate referring physicians based on the value and volume of referrals for designated health services.

2. As explained in greater detail herein, Relators allege Defendants colluded to defraud the LIP program and the CARES Act, and, in doing so, submitted false and/or fraudulent claims for payment to the United States and the State of Florida. Defendants also violated the Federal Stark Law by paying physicians commercially unreasonable compensation in exchange for referrals. The physicians' compensation was not based on fair market value. In doing so, Defendants submitted false claims to the United States for payment for each tainted claim.

3. The FCA provides that any person who knowingly submits or causes to be submitted to the Government a false or fraudulent claim for payment or approval is liable for a civil penalty of $10,781 to $21,563 for each such claim, as well as three times the amount of the damages sustained by the Government. The FCA permits persons having information regarding a false or fraudulent claim that was submitted to the Government to bring an action on behalf of the Government and to share in any recovery. The complaint must be filed under seal, without service on the defendants. The complaint remains under seal while the Government conducts an investigation of the complaint's allegations and determines whether to join the action.

4. Pursuant to the Federal FCA and the State of Florida's FCA, and on behalf of the

United States and the State of Florida, Relators seek to recover damages and civil penalties arising from Defendants' purposeful submission of false and/or fraudulent claims to the Government.

JURISDICTION AND VENUE

5. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1367 and 31 U.S.C. § 3732.

6. This Court may exercise personal jurisdiction over Defendants pursuant to 31 U.S.C. §3732(a) because Defendants transact business in the Middle District of Florida.

7. Venue is proper in this District pursuant to 31 U.S.C. §3732(a) because Defendants can be found in, reside in and/or have transacted business in the Middle District of Florida.

8. Relators know of no other FCA complaints that have been filed against Defendants alleging the same or similar actions for the time period at issue. Additionally, Relators are original sources as defined in 31 U.S.C. § 3730(e)(4)(B). Relators made voluntary disclosures to the United States prior to the filing of this lawsuit.

PARTIES

9. The United States and the State of Florida are the real parties of interest in this action.

10. Relator [redacted] The facts alleged within are based on the personal observation of

Relator [redacted] principal, as well as documents and information in his possession. The information and observations led Relator to question Defendants' fraudulent actions.

11. Relator John Doe is an [redacted] at Relator [redacted]

12. Defendant North Brevard County Hospital District d/b/a Parrish Medical Center ("Parrish") is an independent special taxing district located in the northern portion of Brevard County. The District operates a 210-bed not-for-profit community hospital, an affiliated medical group and related support services, including clinics, home health services, a cancer center, a health and fitness center and various outpatient healthcare facilities. The District also has operations in Port St. John and Port Canaveral.

13. Defendant Halifax Hospital Medical Center is a legislatively-chartered taxing healthcare organization governed by a Board of Commissioners appointed by the Governor of Florida.

14. Defendant George Mikitarian has been President and Chief Executive Officer of the North Brevard Hospital District since January 2001. He supervises, directs and approves operations in the District.

15. Defendant Anual Jackson, Sr. has been the Chief Corporate Compliance and Privacy Officer at the District since 2012. His responsibilities include ensuring that the District operates in a legal and ethical manner.

16. Defendant Christopher McAlpine is the District's Chief Transformation Officer and a Senior Vice President. McAlpine is responsible for strategic planning, business development and strategy at the District.

17. Defendant Eric Peburn is the Executive Vice President and Chief Financial

Officer of Halifax Hospital Medical Center. He joined Halifax in 1996, and was promoted to his current position in 2007.

18. Defendant Jeff Feasal has been the President and Chief Executive Officer of Halifax since January 2005. During his tenure, Halifax has expanded its services throughout the three-county area in which it now operates. Under his leadership, Halifax contracted with Parrish to provide a wide array of services, including information technology and finance. During his tenure, in 2014, Halifax settled a False Claims Act complaint in the amount of $85 million.

The Federal and Florida False Claims Acts

19. The Federal False Claims Act, 31 U.S.C. §§ 3729 *et seq.* reflects Congress' objective to "enhance the Government's ability to recover losses as a result of fraud against the Government." S. Rep. No. 99-345 at 1 (1986). As relevant to this case, the FCA establishes liability for an individual or entity that:

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> (C) conspires to commit a violation of 31 U.S.C. § 3729(a)(1)(A) and (a)(1)(B); and
>
> (D) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.

31 U.S.C. § 3729(a)(1)(A); 31 U.S.C. § 3729(a)(1)(B); 31 U.S.C. §(a)(1)(C); 31 U.S.C. §(a)(1)(G).

20. The FCA defines "knowing" and "knowingly" to mean that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. 31 U.S.C. § 3729(b)(1). No proof of specific intent to defraud is required and an innocent mistake is not a defense to an action under this act. *Id.*

21. In addition to treble damages, the FCA provides for civil penalties for each violation.

22. The State of Florida's FCA is modeled after the Federal FCA, and contains provisions similar to the ones quoted above. Relators assert claims under the FCA and the State of Florida's FCA for the false and fraudulent claims alleged in this Complaint.

The Stark Act

23. The Stark Act, 42 U.S.C. § 1395nn, states that if a physician or member of his immediate family has a "financial relationship" with an entity providing healthcare services:

> (a) the physician may not make a referral to the entity for the furnishing of designated health services...and
>
> (b) the entity may not present or cause to be presented a claim under this subchapter or bill any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A),

42 U.S.C. § 1395nn(a)(1).

24. The regulations implementing the Stark Act state that a "financial relationship" may include "a direct or indirect compensation arrangement . . . with an entity that furnishes

[designated health services]." 42 C.F.R. § 411.354(a)(1)(ii). A "compensation arrangement" can be "any arrangement involving remuneration, direct or indirect, between a physician . . . and an entity." *Id.* at § 411.354(c).

Violations of Stark Can Form the Basis of FCA Liability

25. Compliance with Stark is a precondition for payment from Medicare.

26. An express or implied certification accompanies each claim submitted to Medicare for reimbursement of health services provided to beneficiaries that the transaction is not in violation of federal or state statutes, regulations, or program rules. Falsely certifying compliance with Stark in connection with a claim submitted to a federally-funded health care program is actionable under the FCA.

The Low Income Pool Program

27. On October 19, 2005, the Centers for Medicare and Medicaid Services ("CMS") approved the 1115 Research and Demonstration Waiver Application for the State of Florida, relating to Medicaid reform. The Florida Legislature passed House Bill ("HB" 3B on December 8, 2005, authorizing implementation of the waiver effective July 1, 2006. In the Waiver Special Terms and Conditions ("STC"), the LIP is "established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period." The parameters of LIP are defined in STCs 91-106.

28. STC Number 94 states that "LIP funds may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by

hospitals, clinics, or by other provider access systems ("PAS") and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS."

29. In accordance with STCs Numbers 93 and 100, the State submitted to CMS on June 26, 2006, the first Reimbursement and Funding Methodology document (RFMD) for LIP expenditures, which includes the definition of expenditures eligible for Federal Matching funds under the LIP and entities eligible to receive reimbursement. The STCs together with the Reimbursement and Funding Methodology document govern the LIP program.

The CARES Act

30. The CARES Act was enacted for the purpose of providing fast and direct economic assistance for American workers, families, small businesses and industries. It was passed by Congress and signed into law on March 25, 2020 and signed into law on March 27, 2020. At over $2 trillion, it is one of the largest rescue packages in U.S. history. The law allocated $150 billion to states and localities battling the pandemic and $130 billion more for the healthcare system.

31. According to the Terms and Conditions set forth by the Department of Health and Human Services ("HHS"), in order for a business to participate in the CARES Act program, "the Recipient certifies that it will not use the Payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse."

ALLEGATIONS
Overview and Background

32. Florida created the LIP program to pay providers for the cost of care given to the State's most vulnerable patients. The creation of LIP was done in conjunction with the State's implementation of the Medicaid managed care program in 2005. LIP provides direct payments to

safety-net providers for the provision of health care services to Medicaid patients, as well as to underinsured and uninsured patients.

33. These supplemental payments flow to county health departments, Federally Qualified Health Centers ("FQHCs") and other safety-net providers from a federal program. Contributions from local and state governments match the federal money. Together, the federal, local and state aid to Florida's safety-net healthcare providers initially totaled $1 billion per year. This year, it amounts to more than $1.9 billion.

34. Each year, hospitals, health departments and FQHCs pledge hundreds of millions of dollars to the state Agency for Health Care Administration ("AHCA"). AHCA uses the contributions to draw federal money. The Agency tells the providers they will never receive less than the amount they contributed. In 2016-2017, for example, a contribution of 39 cents returned $1.

35. AHCA requires local government contributors to complete a LIP agreement that spells out their financial commitment, the program rules, the proper use of the aid, audit procedures and record keeping. The healthcare agency bills contributors who must transmit the money by Intergovernmental Transfer ("IGT"). A summary of the program explains:

> Since many health care facilities benefit from IGT funds used for federal match, IGT providers are encouraged to contribute funds in order to ensure maximum payments from the LIP program. Health care providers are encouraged to contact potential IGT providers in their area to secure IGT funding.

36. Florida agreed it would not receive any federal money in excess of allowable costs and that CMS may recoup any overpayments. To comply, AHCA required recipients to calculate a LIP Cost Limit, submit reports detailing the uncompensated care provided and undergo an audit to reconcile the payments. Overpayments for any unallowable costs are

supposed to be returned to CMS. AHCA has been repeatedly criticized for failing to provide adequate oversight and guidance for the LIP program.

37. CMS conducted two Financial Management Reviews of the LIP program covering [state fiscal years] 2007 through 2009 and found that the State agency [AHCA] did not provide hospitals with adequate oversight and guidance. As a result, the hospitals claimed unallowable costs and inconsistently documented, calculated and reported costs.

38. AHCA is supposed to reconcile the LIP payments made to recipients with money provided to these hospitals through other federal and state aid programs that care for the state's poorest and most vulnerable patients, such as Medicaid and the Disproportionate Share Hospital Payments ("DSH").

Legal History Involving CMS, Florida and AHCA

39. From state fiscal year 2007 through 2014, CMS disallowed $146.1 million of federal funds related to LIP overpayments that AHCA did not refund. In an April 14, 2015 letter to Florida, CMS wrote:

> … over time, CMS has had a number of concerns about the LIP [Low Income Pool], including its lack of transparency, encouragement toward overreliance on supplemental payments and distribution of funds based on providers' access to local revenue instead of service to Medicaid patients.

40. As a result of the financial risk uncovered by CMS, the HHS Office of Inspector General ("OIG") audited the LIP program costs and expenditures for the state's largest recipient, Jackson Memorial Hospital in Miami.

41. In August 2019, it recommended Florida return $412 million. Two years earlier, in January 2017, CMS demanded Florida return $97 million in LIP overpayments because the hospitals did not properly offset money received from other federal healthcare programs. Florida

challenged the decision. An HHS appeals board upheld the CMS decision to disallow the money in February 2021.

42. On April 27, 2017, AHCA sued HHS in the U.S. District Court in the Southern District of Florida. U.S. District Court Judge Beth Bloom ultimately closed the case for administrative purposes pending settlement discussions.

43. Florida's reconciliation of LIP payments—the review designed to ensure costs are justified—is deficient. For example, the 2017 fiscal year examination, demonstration year 11, has yet to be completed.

Introduction of Halifax

44. After AHCA's reconciliation for the LIP demonstration year 9 ("DY"), which ended on June 30, 2015, the Halifax Hospital Medical Center Taxing District, d/b/a Halifax Health offered an adjacent hospital district an opportunity for a quick profit with little risk.

45. The controller for the North Brevard County Hospital District, d/b/a Parrish Medical Center, summarized the 2017 proposal in a one-page memo to the Board of Directors:

> The primary purpose of the interlocal agreement is to obtain $200,000 in increased Medicaid funding under the Low Income Pool (LIP) program.
>
> The benefit to Halifax is to relieve it of excess LIP funds it would otherwise owe by designating LIP payments to other public hospitals. The Arrangement will be submitted to the Florida Agency for Health Care Administration (AHCA) to transfer LIP funds in their records.
>
> Under the interlocal agreement, PMC will receive a wire transfer from Halifax in the amount of $4,434,000. PMC will then transfer $4,234,000 to an account identified by Halifax. PMC will remain the difference of $200,000 for providing care to Medicaid, underinsured and uninsured individuals.

46. On November 13, 2017, the two public hospitals memorialized the deal in a five-

page agreement filed with the Brevard County Clerk of Court. The agreement describes the three-step process the two hospital taxing districts used to manipulate the LIP program so Halifax would not have to repay $4 million.

Violation of Federal Rules and Regulations

47. Halifax agreed to reduce its contribution to the LIP program by $4 million and redirected the money to Parrish's benefit. The reallocation decreased the DY9 LIP payments earmarked to Halifax by $4,340,000. It also added $4,340,000 to the LIP distribution Parrish would receive. The transaction effectively removed any LIP overpayment to Halifax.

48. After AHCA approved the reallocation, Halifax agreed to wire transfer $4,340,000 to a PMC account. PMC agreed to return $4,140,000 to Halifax immediately, and then pocketed $200,000.

49. The agreement with AHCA requires LIP recipients to use the supplemental aid to increase the provision of health services for charity care. The letter of agreement said:

> The [IGT Provider] and the Agency have agreed that these IGT funds will only be used to increase the provision of health services for charity care of the [IGT Provider] for the State of Florida at large.
>
> The increased provision of charity care health services will be accomplished through . . . LIP payments to hospitals, federally qualified health centers, Medical School Physician Practices, and rural health centers pursuant to the approved Centers for Medicare & Medicaid Services Special Terms and Conditions.

50. The special terms and conditions of the LIP program explicitly state LIP funds "may be used for health care costs—medical care costs or premiums—that would be within the definition of medical assistance in Section 1905(a) of the ACT."

51. The RFMD provides instructions for calculating the LIP cost limits for hospitals. For DY9, a reconciliation must take place based on the CMS-2552 cost report. The instructions explained:

> If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the Federal government.

52. Parrish violated federal law when it accepted, but did not use, the entire additional LIP allotment of $4,340,000 to care for the Medicaid, underinsured and uninsured patients. Instead, it earmarked $200,000 to provide care for Medicaid, underinsured and uninsured patients. It transferred the remainder-- $4,140,000—to Halifax. Neither the agreement nor the memorandum from then-controller Michael Sitowitz describes any restriction on the use of the money sent from Parrish to Halifax. These agreements do not say the money must be used for charitable care.

Halifax Holds Parrish Harmless

53. Parrish made sure its legal interests were protected. Sitowitz explained in an October 31, 2017 memorandum to the Board of Directors:

> The inter-local agreement provides that Halifax will indemnify PMC for any loss associated with the transaction. The risk of loss for this agreement is very low.

54. The inter-local agreement includes a provision wherein Halifax agrees to indemnify, defend and hold harmless Parrish.

55. Two years later, Parrish and Halifax signed a second agreement designed to manipulate the LIP supplemental funding program for the period covering waiver DY9. In a December 10, 2019 interlocal agreement, Halifax re-designated $1.5 million to Parrish's benefit.

The reallocation decreased Halifax's LIP share and increased Parrish's LIP share by $1,627,500. Parrish agreed to transfer $1,527,500 and pocket $100,000.

56. Again, Parrish accepted, but did not use, $1,557,500 from the LIP program for care of the area's vulnerable in violation of federal law and its agreement with Florida.

57. The agreement indemnifying Parrish states:

> Halifax covenants and agrees to the extent permitted by law, it shall indemnify, defend and hold harmless PMC [Parrish] and its officers, directors, employees and agents from and against any and all losses, obligations, costs, liabilities, damages, actions, suits, causes of action, claims, demands, settlements, judgements or other expenses, which are asserted against, imposed on, or incurred or suffered by, such indemnified party and which arise out of or result from this Agreement.

58. Under both its arrangements with Halifax, Parrish accepted kickbacks in exchange for circumventing the regulations governing a federal program that provides supplemental funds to care for the uninsured and underinsured. Parrish agreed to the deal despite questions raised internally over whether the arrangement was legal.

59. Halifax is in an independent special district, a unit of government created for a particular purpose with jurisdiction within a limited geographic boundary. In Florida, these districts have only those powers expressly provided by, or reasonably implied from, the authority in their charters. They provide specific municipal services in addition to, or in place of, those provided by a municipality or a county in a specific geographic area.

No Authority to Participate

60. In 2017, Halifax's charter limited its operations to a portion of Volusia County. Legally, it did not have the authority to operate outside of its district boundaries, including contracting through inter-local agreements with other government units outside its area.

61. Inter-local agreements "permit local government units to make the most efficient

use of their powers by enabling them to cooperate with other localities to provide services and facilities in a manner pursuant to forms of governmental organization that will accord best with geographic, economic, population and other factors influencing the needs and development of local communities." It is intended to authorize the entry into contracts for the performance of service functions of public agencies.

62. The North Brevard County Hospital District, d/b/a/ Parrish Medical Center, was created as a special taxing district expressly for the purpose of equipping, maintaining and operating a hospital in northern Brevard County. Its enabling legislation permits the District to enter into joint ventures with not-for-profit and for-profit health care ventures operating within and beyond its geographic boundaries.

63. However, the law expressly prohibits the District from using money derived from ad valorem taxes to support any healthcare facility or service operated outside the District's boundaries. The law does not allow the District to purchase stock in such corporations and requires compliance with the Florida Constitution and general laws.

Section 10 of the Florida Constitution says, in part:

> Neither the state nor any county, school district, municipality, special district, or agency of any of them, shall become a joint owner with, or stockholder of, or give, lend or use its taxing power or credit to aid any corporation, association, partnership or person …

64. Despite the prohibitions, Parrish holds investments in two corporate entities selling health care services to patients inside and outside the District's legislatively-set geographic boundaries.

65. LHCG LXXXII, LLC, a hospice and home health care company, operates in

Brevard County as Parrish Home Health Care. LHCG is a subsidiary of LHC Group Inc. of Lafayette, Louisiana, a national provider of in-home healthcare services with operates in 37 states and 30,000 employees.

66. LHC Group advertises itself as the "preferred in-home healthcare partner for more than 400 leading hospital around the country." Last year, LHC Group recorded $2.1 billion in revenue and net income of $111.6 million.

67. Florida health care records identify the owners of LHCG as LHC Health Care Group of Florida LLC, another subsidiary of LHC Group, and North Brevard Medical Support Inc. LHC Health Care Group owns 75 percent of the company. North Brevard Medical Support owns 25 percent.

68. North Brevard Medical Support (NBMS) is a not-for-profit, non-stock corporation and blended unit of the District. According to the District's tax returns, NBMS was created "solely to benefit and further the interests of the District through physician recruitment and the provision of medical goods and services." The hospital taxing district pays millions of dollars to subsidize (See Page 9) the operations of NBMS.

69. Parrish Home Health operates numerous location in Brevard, including the county's second largest city, Melbourne. Melbourne is outside the geographic boundaries of the North Brevard Hospital District.

70. George Mikitarian, the president and CEO of Parrish, described the District's investment in a second for-profit company, MedFast Urgent Care Centers, to Relator John Doe. MedFast runs the largest urgent care network in Brevard County. Its 14 centers span the county, operating both inside and outside the geographic boundaries of the District. MedFast has three centers in Melbourne alone.

71. Parrish spent $1.1 million on a 7,000-square-foot-urgent-care facility on Port St. John Parkway in a venture with MedFast Urgent Care Centers LLC. Dr. David Williams, a MedFast partner, said at the time the company would like to be the "McDonald's of urgent-care medicine – serve it fast and efficiently."

72. Since the venture with Parrish was announced, MedFast has built 12 facilities across the county and has announced plans for two more.

The CARES Act

73. Congress allocated $150 billion to state, local and tribal governments to help pay the increased expenses caused by COVID-19. Other aid packages directed billions of dollars in loans for small businesses, hospitals and health care providers. Florida government alone received $8.3 billion with the state's 12 largest counties allocated $2.5 billion.

74. The CARES Act authorized elected county officials to direct money to cover any "necessary expenditures" incurred due to the public health emergency. The U.S. Treasury said legitimate expenditures included spending to respond directly to the pandemic, such as medical or public health needs, as well as costs to respond to "second-order" effects, such as economic support to those suffering from employment or business interruptions.

75. At their core, the rules initially issued and later refined by the Treasury classified most unbudgeted expenses directly related to the pandemic as legitimate. They excluded efforts to fill shortfalls in government revenue, construction projects and expenses that would be reimbursed under any federal program. A Treasury guide noted:

> The Fund is designed to provide ready funding to address unforeseen financial needs and risks created by the COVID-19 public health emergency . . . Payroll and benefit costs associated with public employees who could have been furloughed or otherwise laid off but who were

> instead repurposed to perform previously unbudgeted functions substantially dedicated to mitigating or responding to the COVID-19 public health emergency are also covered.

76. Brevard County, one of the 12 largest in Florida, received $105 million for county commissioners to direct as they deemed appropriate. On November 5, 2020, a Parrish senior vice president lobbied the five-member commission for $5 million, which would be used, in part, to expand and remodel the emergency room. Its initial request included an upgrade to the gym and patient rooms.

77. Edwin Loftin, the senior vice president of integrated and acute care services and the chief nursing officer, told the commission that Parrish would make substantial improvements in the emergency department, in the universal respiratory care area and in infection prevention innovations.

78. In exchange for the CARES Act money from the County, Loftin said Parrish was "committed to providing 20 percent back to the community." The hospital identified Blanton Park—an impoverished area with a soup kitchen and a county park—as an area that needed community resources.

79. The proposal brought harsh words from Commissioner John Tobia, who questioned how a hospital could ask for $5 million in emergency money, but "magically" have $1 million it could set aside to help a park. Tobia added that the proposal was ridiculous.

80. Initially, the county commission voted to kill the Parrish proposal. Later, supporters circumvented the Parrish "no" vote by allocating $5 million for each commissioner to spend on any project the commissioner deemed appropriate, provided the project was deemed "low-risk." The CARES Act requires the U.S. Treasury to audit expenditures. Brevard County is required to refund any money that does not follow federal spending rules.

81. The $25 million slush fund created for the five individual commissioners accounted for almost one quarter of the county's entire allocation. Commissioner Rita Pritchett directed her $5 million allocation to Parrish.

82. At the time, Parrish had a net financial position of $93.6 million. Its non-operating revenues increased primarily as a result of $7.5 million it had received under the CARES Act program. Additionally, its profit margins increased, primarily from COVID relief programs and increases in investment income. As a direct result of Cares Act money, 2020 was the first year since at least 2014 in which Parrish had not posted a loss. From 2014 through 2019, Parrish showed losses of more than $53 million. In 2020, as a result of false claims made for Cares Act money, Parrish posted an increase in its net cash position of $2,273,000 as opposed to the prior year when it posted a loss or decrease in its net cash position of $8,189,000. Astonishingly Parrish was able to show a profit in 2020, despite 600 fewer or more than a 12% decrease in admissions and nearly 20% fewer outpatient visits.

83. The special taxing district, the North Brevard County Hospital District, received $10.1 million under the federal Department of Health and Human Services ("HHS") provider relief program. The North Brevard Medical Support, Inc., an affiliate that supplies medical goods and services, received $294,326 in HHS provider relief funds and $1.4 million in federal Payback Protection Loans.

84. Together, CARES Act money directed to Parrish totaled $11.8 million, not counting the $5 million funneled to the North Brevard hospital system by the county commission. The agreement with the commission says:

> (a) Are necessary expenditures incurred due to the public health emergency with respect to COVID-19; and

(b) Were not accounted for in the Hospital's Budget most recently approved as of March 27, 2020; and

(c) Were or will be incurred during the period that began on March 1, 2020, and ends on December 30, 2020. The expense is incurred when the County has expended the funds to cover the expense or reimbursed the Hospital for the expense.

85. Initially, a quarter of the COVID-related expenses amount to an emergency room expansion and remodeling, moving and rebuilding the members-only Health and Fitness Center, replacing doors so they open automatically and adding an electronic patient-tracking system that better allows the hospital to document and coordinate patient care.

86. The U.S. Treasury limited capital expenditures and the expenses of acquiring or improving property to increases in COVID-19 treatment capacity:

> If capital improvement projects are not necessary expenditures due to the COVID-19 public health emergency, then Fund payments may not be used for such projects. . . . Fund payments may be used for the expenses of, for example, establishing temporary public medical facilities and other measures to increase COVID-19 treatment capacity or improve mitigation measures, including related construction costs.

87. Four months after it applied for CARES Act money from the county, the hospital system announced plans to convert the existing Parrish Health & Fitness Center into an orthopedic and sports performance center of excellence. The plan required moving the 5,500-foot fitness center to a new location that, Parrish said, would open in the fall of 2021.

88. Parrish initially sought $200,000 from the county CARES Act money to move "the location of the community Health & Fitness Center to appropriately adhere to safe workouts in accordance with socially distancing guidelines. Build-out new gym space." It characterized the project as "reorganization – Social Distancing Gym."

89. County payment records do not show CARES Act expenditures for the gym.

However, they include $142,000 due the facility's management company. Documentation supplied by Parrish to the County show separate invoices of $87,000 and $85,000 for estimated payroll and management fees. The U.S. Treasury guidance said CARES Act money can only be used to cover costs that were not accounted for in the most recently approved budget. It explained:

> A cost meets this requirement if either (a) the cost cannot lawfully be funded using a line item allotment, or allocation, within the budget *or* (b) the cost is for a substantially different use from any expected use of funds in such a line item, allotment or allocation.

90. It paid $65,500 to replace five hospital doors with touchless automatic doors. Additionally, it allocated $948,777 in construction costs for its emergency room expansion and remodeling project. As justification for use of CARES Act money, Parrish said:

> Construction will convert temporary COVID-19 measures into long-term, safe environments to meet the changing demands for patient care at Parrish Medical Center.

91. Parrish first asked for Brevard County to provide up-front funding for the construction work. The county refused. Shannon Wilson, the deputy county attorney, wrote in a a February 22, 2021 email to Parrish Vice President Loftin:

> Can you give the County a "ballpark" estimate for construction?
>
> Do you have any signed contracts at this point? This would be a good time to begin thinking about the documentation the County will need in order to reimburse Parrish.

92. Wilson explained to Thomasina Middleton of Parrish's financial planning division that:

> . . . the County really hasn't funded any other projects like this with CARES dollars. We had some discussion about submitting expenses on an on-going basis, to come up with a method that would help avoid duplication of submissions, etc.—the County would not pay on a

> piecemeal basis, it would still be a lump sum at the completion of the project.

93. She added in an email to the county budget director:

> At some point, we need to sit down and have a discussion about how to manage the submission of expenses, billings, etc., for this Parrish project.

94. In May 2021, Brevard County began making payments on the "emergency department and patient room remodel" project. First, it paid $55.849 to reimburse Parrish for starting the project. In June, it paid $121,604.63 for continued work. This fall, it paid another $459,996.53 in late September to cover expenses incurred in June, August and September. The payments totaled $637,450.

VIOLATIONS OF STARK

95. Defendants entered into improper compensation arrangements and other arrangements that (1) exceeded fair market value; (2) were not commercially reasonable; or (3) took into account the value or volume of referrals or other business generated, in violation of Stark.

96. Both laws contain exceptions and safe harbors for certain types of financial relationships. Generally, these exceptions require that compensation is consistent with fair market value, is determined without considering—directly or indirectly—the volume or value of referrals and that the arrangements are commercially reasonable.

97. Parrish ignored the requirements set out by Stark. It paid numerous doctors compensation far in excess of prevailing standards. Executives knew the salaries were excessive, and that it would lose money on certain physician practices because of those salaries. The District justified the exorbitant salaries by tracking downstream revenue in the form of physician referrals and each doctor's contribution margin to the bottom line.

98. The North Brevard County Hospital District operates a 210-bed, non-profit hospital located in Titusville, Florida. The District has several subsidiaries, including a medical group that employs primary care and specialty physicians. For at least the last seven years, the District, which has not raised taxes in more than 25 years, has experienced financial difficulties with annual losses of more than $8 million.

99. By 2018, senior executives intensified efforts to direct referrals to the hospital, its specialists and its affiliates to stop what they deemed "outmigration"—the practice of referring outside the Parrish network. Parrish estimated the loss of these lucrative referrals cost the health system $4 million per year.

100. Gregg Sargent, the director of operations at Parrish Medical Group, notified staff that outmigration of patient cases had to change. In an April 5, 2019 email, Sargent wrote:

> "I have been given a directive to help reduce the outmigration of patient cases. In the last 12 months there has been over 4 million in total value of referrals outside of our network. This has got to change if we are going to improve the financial health of our group. Referrals outside of the network should only occur if insurance dictates."

101. Sargent's email listed the Parrish in-network providers for five key practices: cardiology, orthopedics, gastroenterology, ophthalmology and urology. The reports break down the referrals inside and outside the network by doctor. After capital contributions, the District lost more than $53 million from 2014 through 2019, reducing its net position.

102. One physician quit rather than submit to the directives. A month later, in May

2019, Ben Nettleton, D.O. wrote to Parrish President Mikitarian to negotiate a "fair" contract amid questions over the doctor's referral practices:

> "I recognize Parrish is trying to stay afloat financially, but I believe I do not wish to become the physician Parrish and [redacted] are trying to force me to become. If I stay in your system there will continue to be distracting strife and dissonance.
>
> If you want or need someone who will bend referrals to your will, I may not be that physician as well. I have an obligation to do what is best for my patients, and I am still learning the specialists, but please note that I do not maliciously re-route patients out of your network unless requested by the patient or if I believe it is in the best interest of the patient to do so."

103. In the May 10, 2019 email, Nettleton defended his medical judgement with a point-by-point defense of his decisions to refer outside the Parrish network. Many of his patients, he wrote, live too far away to travel to the Parrish Medical Center for treatment. He added:

> "Cardiology- Dr. Rao. [A physician outside the Parrish network] This is the big one. I stopped going out of my way to send patients to him in July 2018, even though I feel he is a good cardiologist, because so is Dr. Matthews and I have no reason to not utilize him.
> However, many patients are established with Dr. Rao already, and others request him, and I cannot conscientiously re-route those when I do not believe it is in the best interest of the patient to do so."

104. Neither the requested meeting with Mikitarian, nor the "fair contract" occurred.

An hour after Nettleton's email, Mikitarian informed the principal at Relator [redacted] that he would not meet with the doctor. The company president sent Nettleton an email accepting Nettleton's resignation. Mikitarian circulated another response to Relator [redacted] principal:

> "The guy is a lunatic."

105. Its physician contracts emphasized the District's referral policies. A draft agreement for E. Wayne Mosley, M.D., an orthopedic surgeon, said:

> "Physician shall exclusively utilize Hospital, its subsidiaries and affiliates, including but not limited to Parrish Health Network for the provision of the services referenced herein, as well as all related ancillary and other services that Physician may order in connection therewith, except in any of the following circumstances:
>
> - The patient expresses a preference for a different provider or supplier; after physician has indicated their exclusive use of Hospital services
> - The patient's insurance determines the provider or supplier
> - In physician's judgment, doing so would not be in the patient's best medical interests."

106. The agreement explains that the contract provision "shall not be construed" to require the physician to refer patients to Parrish Medical Center, its subsidiaries or affiliates. However, doctors were acutely aware that they were to refer patients to the District.

107. Parrish regularly tracked referrals, the revenue generation of its employed physicians and their "contribution margin"—the sum of net payments minus direct costs. It then loaded the contribution margin by specialty into a referral management tool to calculate the value of "leakage."

108. Aggregated reports showed the "Leakage Trends" by practice and by month, the reason for the referral, the top out-of-network providers and the Parrish alternatives. From April 2018 through March 2019, a consultant to the District estimated the out migration totaled $4.7 million. Out-of-network providers received between 26 percent and 29 percent of all of the District's patient referrals.

109. Cardiovascular services, for example, referred 398 patients outside the

Parrish network. Cardiologists did not provide a reason for the referral for 274 of the patients. The hospital district estimated the referral value at $1.2 million. A second practice, Orthopedics, placed 241 patients with out-of-network providers at an estimated value of $851,041.

110. Detailed reports broke out the number of referrals by doctor and listed the percentage directed toward other providers. Income reports tracked revenue and direct expenses by physician and the practice. The income report for the neuro//ortho practice headed by Dr. Mosley shows a substantial loss, a loss nearly equal to his salary. His productivity was in the 10th percentile. A management company, brought in by Parrish to help improve its financial position, questioned how the arrangement with Mosley was sustainable. These income reports did not include the downstream revenue accrued by the 210-bed Parrish Medical Center.

111. The income report shows a net operating loss of $591,472 for Mosley and a loss of $1.1 million for the practice. The report lists the contractual obligation to Mosley at $522,168. His draft contract showed a base salary of $600,000.

112. Parrish budgets for practice after practice to lose money. Overall, it planned for the practices to lose $1.4 million through February 2019. They lost $1.6 million, in large measure from excessive compensation paid to physicians.

113. Stark and related regulations provide exceptions for certain compensation arrangements, including bona fide employment relationships, personal services arrangements, fair market value arrangements and indirect compensation relationships. To qualify for these exceptions, these arrangements must meet these statutory requirements:

- Remuneration must be at fair market value and not based on the value or volume of referrals; and

- Remuneration would be commercially reasonable even in the absence of referrals from the physician to the hospital.

42 .S.C. §§ 1395nn(e)(2)(B) and (e)(2)(C).

114. Defendants knowingly made decisions to pay compensation in excess of fair market value, taking into account the value or volume of services generated to the hospital from referrals. They selectively ignored losses and other factors that rendered these contracts not commercially reasonable to maintain revenue generated from patient referrals.

115. From 2017-2021, [redacted] managed the Parrish Medical Group. Its duties included evaluating the medical needs of the community, communicating with employees and doctors and recruiting physicians. At the medical group's internal meetings, employees and physicians frequently complained about the service provided by cardiologists in North Brevard.

116. Despite the staff's complaints and a documented need for additional services, Parrish revoked or refused to renew the medical privileges of at least four cardiologists over the last decade. The medical group requested the system hire additional heart specialists. Omni was not permitted to recruit or hire them.

117. Relator [redacted] understood the decision not to recruit or hire cardiologists rested upon an "arrangement" between the hospital system and the existing cardiology practices in North Brevard.

118. Some practices were paid to refer their patients to the medical center. Parrish purchased the nuclear medicine equipment of one cardiology group, which then assigned their employees to Parrish and referred all of their nuclear studies and their patients to the health care system and its medical group. At about the same time, Dr. Biju Mathews, a member of the cardiovascular group, received a medical directorship engineered by Parrish.

Parrish and ilumed, LLC

119. In January 20222, the Parrish Health Network adopted a value-based care model designed to reduce costs and provide greater financial incentives to physicians who better manage the care of their patients. It engaged ilumed, LLC of Jupiter, Florida, an entity which had been awarded a Medicare Direct Contract from CMS.

120. Under these programs, a Direct Contracting Entity ("DCE") receives payment from CMS for each payment attributed to the DCE. CMS pays a per-patient-per-month fee to the DCE, which, in turn, pays the doctors who contract with it to provide care. The DCE profits if the monthly costs are lower than negotiated, and loses money if the expenses are higher. Illumed engaged a third party administrator to pay hospitals, primary care physicians, speciallists and other providers with monies it received from CMS.

121. CMS explained in a fact sheet that providers will continue to submit claims to Medicare, but will receive payments directly from the DCE "according to established agreements with the DCE."

122. DCEs are required to contract with providers prior to notifying CMS that the providers are members of the DCE.

123. ilumed describes the arrangement on its webpage:

> Unlike most ACOs and MA Plans, the ilumed DCE does not take a large percentage off the top for administrative costs. Therefore, we can share with our physician partners a larger percentage of the gains created from improved outcomes.
>
> This new risk-sharing arrangement gives you, as a DCE participant, the opportunity to realize Medicare savings created by appropriately aligning

patients via claims, voluntary alignment, and reducing utilization as a result of providing quality care focused on patient engagement and improved outcomes.

124. The company concluded its description of the program by asking doctors to contact ilumed if they would "like to participate in this great new opportunity, ilumed will gladly assist in reviewing the ilumed partnership risk-sharing options in this value-based model."

125. ilumed implemented its program without contracting directly with several hundred doctors in the Parrish Health Network.

126. The doctors provided services, submitted claims to Medicare and ilumed withheld payment. For example, Relator does not have a contract with illumed, nor did other providers who agreed to participate in the Parrish Health Network. Five physicians employed by [redacted] provided care and submitted claims worth several hundred thousand dollars to Medicare. iLumed withheld payment.

127. ilumed's decision to implement the DCE program without established contracts in place with providers violates a fundamental requirement put in place by CMS and raises questions about whether Parrish and the Jupiter-based healthcare management company reaped an impermissible financial benefit by withholding monies from physicians who provided services to patients covered by Medicare.

Claims for Services Provided by Another

128. For approximately three months in 2021, a doctor employed by Relator treated patients referred by the emergency department at the Parrish Medical Center, performed surgery and provided inpatient and outpatient care. By its own admission, Parrish never executed an

employment agreement with Dr. Miller, nor did they agree to lease his services from Relator. Despite the absence of any agreement to bill for services provided by Dr. Miller, Parrish billed government payors for services provided by Dr. Miller.

DAMAGES

129. Relators estimate the damages caused by Defendants' collective actions are in excess of $10 million.

RETALIATION

130. In March 2021, Relators [redacted] John Doe raised concerns to the President, Chief Financial Officer and Chief Compliance Officer of Parrish, alerting them to the fact that the hospital district was violating the FCA. After raising those initial concerns, Relators uncovered evidence, described above, that Parrish has received improper payments through the LIP and CARES Act programs.

131. [redacted] John Doe, an agent of [redacted] attempted to provide evidence documenting the fraud to Parrish's Chief Compliance Officer, the Chief Financial Officer and President. The senior executives ignored Relators' concerns.

132. Rather than investigate Parrish, at the direction of the senior executives, retaliated. It blocked email addresses, terminated contracts and leases, and filed lawsuits against Relator [redacted] Defendant Mikitarian sued Relator [redacted] its principal, [redacted], for defamation.

133. The defamation lawsuit alleged Relator [redacted] a third defendant, Frank Harrison, wrongfully accused Mikitarian and Parrish of fraud, conspiracy and violations of the False Claims Act. The lawsuit alleged that "Harrison," the third defendant, is a fraudulent

alias used or controlled by [redacted]. The lawsuit was dismissed with prejudice after a hearing on January 13, 2022.

134. Correspondence to the media, members of Parrish's Board of Directors and other community leaders describes the arrangements between Parrish and Halifax, which involved manipulation of LIP funds. A letter to Robert Jordan, the Chairman of the hospital's Board of Directors, said:

> These financial transactions, in which millions of dollars have been exchanged between these institutions suggest that these institutions have misrepresented information to AHCA for their own benefit and to the detriment of other institutions that participate in the Low Income Pool.
> On the surface it appears that both institutions conspired to launder government money. Your board approved these transactions knowing full well they were illegal.

135. When senior officials at Parrish refused to take action, [redacted] brought the matter to the attention of the Office of Inspector General at AHCA. The OIG granted [redacted] whistleblower status under Fla. Stat. §112.3187.

136. The OIG is currently investigating AHCA's role in the transaction between the two hospitals. In a September 17, 2021 letter to [redacted], Inspector General Mary Beth Sheffield wrote:

> . . . the allegations related to actions by the hospitals to launder money does not fall under the AHCA OIG purview; therefore, it is recommended you contact the U.S. Department of Justice for those concerns.

137. Retaliation by Parrish against Relators [redacted] Doe—which occurred after Relators' efforts to disclose substantial fraud by the hospital district against government programs—resulted in termination of contracts worth millions of dollars, and substantial legal

expenses incurred by [redacted], which were used to fight the arbitrary and capricious actions taken against it and Doe.

COUNT 1

Violations of the Federal False Claims Act and the Stark Act

138. Relators incorporate paragraphs 1-137 of this Complaint as though fully set forth herein. This Count sets forth claims for treble damages and civil penalties under the FCA.

139. As described in greater detail above, Defendants defrauded the Government by abusing and manipulating the LIP Program and the CARES Act for their financial gain, and at the expense of taxpayers and those citizens for whom the funding was intended to help. Additionally, Defendants engaged in the submission of claims which Defendants knew were tainted by violations of the Stark statute.

140. Under the FCA, Defendants have violated:

i. 31 U.S.C. § 3729(a)(1)(A) by knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval;

ii. 31 U.S.C. § 3729(a)(1)(B) by knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;

iii. 31 U.S.C. § 3729(a)(1)(C) by conspiring to commit a violation of 31 U.S.C. by conspiring to commit a violation of 31 U.S.C. § 3729(a)(1)(A) and (a)(1)(B); and

iv. 31 U.S.C. § 3729(a)(1)(G) by knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay

or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.

141. Because of Defendants' submission of false and/or fraudulent claims, the United State has suffered damages, and is therefore entitled to a recovery of an amount to be determined at trial, plus a civil penalty of $10,781 to $21,563 for each such claim.

COUNT II

Violations of the Florida False Claims Act and the Stark Act

142. Relator incorporates paragraphs 1 through 137 of this Complaint as though fully set forth herein. This count sets forth claims for treble damages and forfeitures under the Florida False Claims Act, Fla. Stat. § 68.081, *et seq*.

143. As described in greater detail above, Defendants defrauded Government health care programs, including the Florida Medicaid program, by conspiring to submit and/or causing the submission of false and/or fraudulent claims in conjunction with abuse of the LIP program and the CARES Act, as well as the submission of claims which Defendants knew were tainted by violations of the Stark statute.

144. Under the Florida FCA, Defendants have violated:

i. Fla. Stat. § 68.082(2)(a) by knowingly making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by an agency;

ii. Fla Stat. § 68.082(2)(b) by knowingly making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by an agency; and

iii. Fla. Stat. § 68.082(2)(c) by conspiring to commit a violation of subsections (a) and/or (b).

145. Because of the false claims made by Defendants, the State of Florida has suffered

and continues to suffer damages, and is therefore entitled to a recovery as provided by the Florida FCA of an amount to be determined at trial, plus a civil penalty for each violation.

COUNT III

Retaliation Under the Federal False Claims Act

146. Relators incorporate paragraphs 120-137 of this Complaint as though fully set forth herein. This Count sets forth claims for treble damages and civil penalties under the FCA.

147. Under the FCA, 31 U.S.C. § 3730(h), an "employee, agent, or contractor" who, because of their efforts to stop a violation of the FCA, is "threatened, harassed, or in any other manner discriminated against," is entitled to relief.

148. As alleged in detail above, Relators engaged in lawful acts in furtherance of their efforts to stop Defendants' fraudulent actions regarding the LIP program. Therefore, they are entitled to compensation to make them whole, as well as special damages, to include litigation costs and reasonable attorney's fees.

PRAYER

WHEREFORE, Relator, on behalf of the United States and the State of Florida, respectfully requests that:

a. This Court enter an order determining that Defendants conspired to violate the FCA and the Florida FCA by making false statements and records to cause false claims to be submitted to the United States and the State of Florida;

b. This Court enter an order requiring Defendants to pay treble damages and the maximum civil penalties allowable to be imposed for each false or fraudulent claim presented to the United States and each false or fraudulent claim presented to the State of Florida;

c. This Court enter judgment against Defendants pursuant to 31 U.S.C. § 3730(h), including an award to Relator of two times the amount of damages sustained as a result of Defendants' actions, as well as litigation costs and reasonable attorney's fees;

d. This Court enter an order requiring Defendants to pay all expenses and attorney's fees and costs associated with this action;

e. This Court enter an order paying Relators the maximum statutory award for their contributions to the prosecution of this action; and

f. Any and all other relief this Court deems to be reasonable and just.

PLAINTIFFS/RELATORS DEMAND A TRIAL BY JURY ON ALL COUNTS.

Dated: [redacted]

Respectfully submitted,

[redacted]

Office of the Inspector General
Report of Investigation
21-06-014

Response 2

From: [redacted]
To: Anderson-Cordova, Roberto; Langston, Brian
Cc: [redacted]"
Subject: Response to AHCA IG Draft Investigative Report
Date: Monday, November 6, 2023 4:35:25 PM
Attachments: Response to AHCA IG Draft Investigative Report.pdf

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Mr. Langston,

Please see attached.

[redacted]

[redacted]

November 6, 2023

Brian Langston
Inspector General
Office of the Inspector General
2727 Mahan Drive
Tallahassee, FL 32308
Brian.langston@AHCA.myflorida.com

Dear Mr. Langston:

I am in receipt of your letter dated October 17, 2023 which describes your office's investigation into AHCA OIG complaint #21-06-014. I would like to thank you and your staff for your efforts to investigate any wrongdoing by the Agency for Health Care Administration.

I have reviewed the notes of your office's interviews with current and former employees of AHCA, the documentary and testimonial evidence, and your recommendations and conclusions. In summary, I disagree with your conclusion that the allegations that unknown Division of Medicaid employees redistributed LIP funding between hospital taxing districts in violation of the Centers for Medicare and Medicaid Services are unsubstantiated. My conclusion following the review of your report is that you failed to interview individuals at HHS-OIG, Parrish Medical Center, the USDOJ, attorneys representing AHCA, employees of the South Broward Hospital District, CMS and others who like those individuals you did interview, support the conclusion that the allegations made against AHCA were substantiated.

Prior to filing the complaint more than several years ago, I and investigators engaged by me interviewed numerous employees at the Agency for Health Care Administration, Parrish Medical Center, Halifax Medical Center, the Center for Medicaid and Medicare Services and auditors at HHS-OIG. I believe all of this information was provided to your office. I note that your investigation did not include interviews with many, if not all, of these individuals. In addition, I reviewed the following documents:

1. Low-Income Pool Intergovernmental Transfers-undated AHCA document.

2. Reimbursement and Funding Methodology for Demonstration Year 9, Florida's 1115 Managed Medical Assistance Waiver Low-Income Pool dated July 10, 2015.

[redacted]

[redacted]

3. A letter dated May 26, 2015 from Justin Senior, Deputy Secretary for Medicaid, State of Florida to Ms. Heather Hostetler, at the Centers for Medicare and Medicaid Services with an amendment request for the low-income pool.

4. Florida Agency for Health Care Administration, DAB No. 3031 (2021), docket A-17-64 dated February 25, 2021. This board decision clearly provides an overview of the Medicaid program, and an overview of Florida Section 1115 Waiver Demonstration project. The board reviewed Florida's LIP payment reconciliation schedules and determined that LIP payments exceeded the provider's LIP cost limits in each demonstration year 1 through 8 disallowing more than $146 million in LIP expenditures. An additional amount in excess of $97 million was also disallowed. It was determined that CMS properly disallowed the LIP payments.

As stated in this report, the LIP program does not allow hospitals to pool their cost data as was performed by Halifax and Parrish. Additionally, funds from the low-income pool program may only be used for healthcare costs that would be within the definition of medical assistance in Section 1905 (a) of the Act (Title XIX) 1902 (a) (10) (A). It was made clear in the documents provided to you by me that Halifax and Parrish used LIP funds for administrative purposes to include accounting, marketing and other services that clearly do not meet the definition of medical care costs. This is not permissible under the rules. Individuals at AHCA should have known and enforced these rules. If they were aware of the rules, they knowingly violated the rules. It does not appear in your report that you ever asked these questions during your investigation.

There is also no evidence in your report or in the documents that we reviewed, that AHCA ever audited the information submitted to it by Halifax and Parrish.

It was made clear by the Department of Health and Human Services and the Departmental Appeals Board Appellate Division Report, (page 21) that hospitals may not aggregate LIP eligible costs to determine LIP funding. Nevertheless, AHCA distributed LIP funds improperly based on the submissions by Halifax and Parrish.

[redacted]

In your report, you indicate that you spoke with Kent Bailey, director of corporate treasury at Halifax. Mr. Bailey has worked for Halifax for more than 13 years and spent several years at Parrish. During your interview with Mr. Bailey, he admitted that Halifax and Parrish conspired to redistribute LIP funds to avoid overpayment. This payment arrangement between Halifax to Parrish is clearly illegal. Moreover, Halifax had no legal authority to operate outside of its tax district, and this fact has been upheld by the Florida Supreme Court. To the extent anyone at AHCA reviewed the interlocal agreements, this should have been obvious to them. Finally, there is no written evidence that AHCA ever approved the 2019 inter-local agreement. Assuming there is written evidence that AHCA approved other intergovernmental transfers between hospitals who pooled their financial information, this alone is an indication that the allegations I made are substantiated.

Finally, I would suggest that Mr. Bewley, outside legal counsel to Halifax, advised that he had a follow-up conversation with Mr. Davis, an employee of South Broward Hospital District. The recent HHS settlement with Florida indicates that this hospital district has also violated LIP fund rules and Florida's and the Federal government's False Claims Act with AHCA's knowledge and possible approval.

As you are aware, Florida and the University of Miami recently agreed to pay CMS and HHS in excess of $400 million as a result of litigation regarding overpayment of LIP funds. Based on this settlement, it is incomprehensible that you could have determined that the allegations I made against AHCA, Halifax and Parrish are unsubstantiated.

If you have any questions regarding the information contained in this letter, the documents referenced herein, or the referenced interviews which led us to our conclusion that the Agency for Health Care Administration violated the rules and regulations for LIP fund distribution, I would be happy to speak to you at your convenience.

Sincerely,

[redacted]

[redacted]

[redacted]

Office of the Inspector General
Report of Investigation
21-06-014

Response 3

From: [redacted]
Sent: Thursday, November 9, 2023 8:02 PM
To: Langston, Brian; Anderson-Cordova, Roberto; cig@eog.myflorida.com; [redacted]
Subject: AHCA IG Exibits
Attachments: Review of AHCA IG Investigative Exhibits.pdf

Asrequested. please see attached.
[redacted]

[redacted]

November 8, 2023

Brian Langston
Inspector General
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
Brian.langston@AHCA.myflorida.com

Dear Mr. Langston:

I am writing in follow up to receipt of the exhibits to CIG case #2021-07-15-0011, AHCA OIG case #21-06-014. The report is dated October 17, 2023 and I received the exhibits to the report today.

These exhibits further support my opinion and position that the allegations initially made that unknown Division of Medicaid employees redistributed LIP funding between hospital taxing districts in violation of Centers for Medicare and Medicaid Services (CMS) guidelines are substantiated. This conclusion is based on documentary evidence obtained from our investigation several years ago, and interviews with employees of HHS-OIG, AHCA, Parrish Medical Center, CMS and Halifax Medical Center. Review of the exhibits provided by you include communications between employees of AHCA and Halifax, employees of Halifax and Parrish Medical Center (North Brevard County Hospital District) interlocal agreements, and interoffice e-mails between employees of AHCA. The exhibits include excerpts from an HHS-OIG report that clearly states that hospitals must use LIP funds for medical care and that redistributions can be made at the state's discretion, but must be approved by CMS prior to redistribution. There is no evidence that CMS ever approved the redistributions or distributions either verbally or in writing, and this is confirmed by the information provided in the exhibits. In addition, there is an e-mail from Kim Kellum to several employees of AHCA, forwarding an e-mail from Phil Blank who was employed by the South Broward Hospital District that filed an IGT with the Halifax special tax district, that claims that each district has the authority to determine and designate what hospitals will receive what portion of LIP amounts are to be provided based on the level of uncompensated and indigent care provided. This outline is clearly in violation of CMS guidelines and was presumably approved by AHCA. Finally, an e-mail from Lecia Behenna at AHCA recommended that AHCA contact CMS regarding these arrangements. This e-mail was sent to CMS, as well as AHCA officials. Despite this acknowledgement that approval was necessary, there is no evidence that anyone at CMS ever approved this conduct or these redistributions.

[redacted]

[redacted]

[redacted]

In summary, I do not believe that the documentary evidence or the exhibits you provided support the finding in your draft letter of October 17, 2023. In fact, they further substantiate that AHCA never obtained CMS approval, and in fact violated the guidelines set forth in the rules established by CMS under the 1115 Demonstration Waiver.

If you would like to discuss this issue further, or have any questions, please do not hesitate to contact me.

Sincerely,

[redacted]

[redacted]

[redacted]