

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**

**South Carolina Department of Health and
Human Services,**

Petitioner

v.

Centers for Medicare & Medicaid Services,

Respondent

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Reconsideration of Disapproval

**South Carolina Medicaid State Plan
Amendment Nos.:
16-0012-A, 17-0006-A, 18-0011-A**

**Hearing Officer Docket No.:
SPA 2020-1**

PROPOSED DECISION OF THE PRESIDING OFFICER

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Hearing Officer Docket No. SPA 2020-01

I. ISSUES

Whether the South Carolina Department of Health and Human Services (SCDHHS or the State) State Plan Amendments (SPAs) 16-0012-A, 17-0006-A and 18-0011-A are inconsistent with the requirements of:

1. Section 1902(a)(2) of the [Social Security Act (SSA or the Act)], which provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.
2. Sections 1903(a) and 1905(b) of the Act, which provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.
3. Section 1903(w)(6)(A) of the Act, which allows states to use funds derived from state or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under section 1903 of the Act.

SCDHHS Exhibit 23 (84 Fed. Reg. 54905, 54905-06 (Oct. 11, 2019)).

II. SUMMARY OF THE PROPOSED DECISION

The Centers for Medicare & Medicaid Services (CMS) correctly determined that the SPAs should be denied because they failed to provide an adequate source of funding for the state share of the proposed Medicaid plans. Based upon the relationship between Greenville Health Authority (GHA) and the hospitals at issue, Prisma Health Greenville Memorial Hospital (PHGMH) and Prisma Health Richland Hospital (PHRH), the funds meet the statutory definition of non-bona fide donations, which are not a permissible funding source for the non-federal share of Medicaid payments. Section 1903(a)(1), (2), (6) of the Act; *see* section 1902. Without a permissible funding source for the non-federal share of Medicaid payments, a state's expenditures do not qualify to be matched with federal funds in accordance with sections 1903(a) and 1905(b) of the Act. Under such circumstances, the state would not receive any statutorily determined FMAP. The non-federal share of the payments proposed in SPAs 16-0012-A, 17-0006-A and 18-0011-A would not originate from a permissible source.

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III. PROCEDURAL LEGAL AUTHORITY — MEDICAID STATE PLAN REVIEW PROCESS AND APPEAL PROCEDURES

Medicaid was enacted in 1965 as Title XIX, Grants to States for Medical Assistance Programs, of the Act. Title XIX authorizes the Secretary of Health and Human Services (Secretary of HHS) to make federal funds available to assist states in providing medical assistance to persons whose income and resources are insufficient to meet the costs of necessary medical services or to persons who are poor, blind, aged and disabled. SSA § 1901 (42 U.S.C. § 1396). Medicaid is jointly financed by the federal and state governments and is administered by the states. The Secretary has the authority to issue regulations under Medical Assistance Programs and has delegated the responsibility for approving state plans and state plan amendments to CMS, which is a component of HHS. 42 C.F.R. §§ 430.1, 430.14, and 430.15. Participation in the Medicaid program is voluntary, but once a state elects to participate, it must operate its program in compliance with federal law. *See Harris v. McRae*, 448 U.S. 297, 301-02 (1980).

States are given a great deal of discretion in designing their Medicaid plans to meet their particular needs. *See Beal v. Doe*, 432 U.S. 438, 444 (1977); *Addis v. Whitburn*, 153 F.3d 836, 840 (7th Cir. 1998). Although a state has some flexibility in designing its plan to consider the state's unique circumstances, the plan must comply with all statutory and regulatory requirements. *See generally* 42 U.S.C. § 1396 *et seq.*; 42 C.F.R. § 430.0 *et seq.*

States that choose to participate in the Medicaid program must submit to HHS/CMS a comprehensive state plan for medical assistance that describes the program and contains assurances that it satisfies all requirements of SSA § 1902(a) (42 U.S.C. § 1396a(a)). The regulations at 42 C.F.R. Part 430 implement the statute and establish requirements, standards, procedures and conditions for obtaining and continuing to receive federal financial participation. 42 C.F.R. §§ 430.1, 430.3, 430.14, 430.15, 430.18. Program regulations state that, “[w]ithin broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.” 42 C.F.R. § 430.0.

The regulation at 42 C.F.R. § 430.12(c) dictates, in relevant part, that states have an obligation to update plans as follows:

- (c) **Plan amendments.**
 - (1) The plan must provide that it will be amended whenever necessary to reflect—
 - (i) Changes in Federal law, regulations, policy interpretations or court decisions; or
 - (ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program. . . .
 - (2) Prompt submittal of amendments is necessary—
 - (i) So that CMS can determine whether the plan continues to meet the requirements for approval

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The regulation at 42 C.F.R. § 430.16 delineates that CMS may ask for additional information as it reviews the SPA submission. Under section 1116(a)(1) of the Act (42 U.S.C. § 1316(a)(1)), the SPA review process requires “a determination as to whether [a SPA] conforms to the requirements” set forth in the applicable subchapter within the Social Security Act. Similarly, the regulation at 42 C.F.R. § 430.15(a) provides:

(a) **Basis for action.**

- (1) Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet the requirements for approval are based on relevant Federal statutes and regulations.
- (2) Guidelines are furnished to assist in the interpretation of the regulations.

Section 1116(a)(1) of the Act and the implementing regulation at 42 C.F.R. § 430.18 indicate that states dissatisfied with a state plan disapproval determination by CMS may request a reconsideration hearing. The regulation at 42 C.F.R. § 430.3(a) provides the right to a hearing regarding disputes that pertain to whether a state plan or a state’s practice under the plan meets federal requirements. Further, the regulation at 42 C.F.R. § 430.60(a) states that appeals involving the decision to disapprove a SPA are reviewed on the basis of whether the plan is “in compliance with Federal requirements.” The regulations at 42 C.F.R. §§ 430.66 and 430.102 provide that the CMS Administrator may designate a Presiding Officer to conduct a hearing and issue recommended findings and a proposed decision. The CMS Administrator specifies the issue(s) to be considered at the hearing. 42 C.F.R. § 430.70(b). A Notice of Hearing, which sets out the issue(s) under dispute and identifies the applicable sections of the Social Security Act and regulations for the appeal process, is published in the Federal Register. 42 C.F.R. § 430.70.

IV. SUBSTANTIVE FEDERAL LEGAL AUTHORITY

A. PUBLIC FUNDS AS THE STATE SHARE OF FINANCIAL PARTICIPATION

As noted above, Medicaid is jointly financed by the federal and state governments. The federal share of expenditures, otherwise known as Federal Financial Participation (FFP), varies largely based on each state’s Federal Medical Assistance Percentage (FMAP). SSA §§ 1903(a), 1905(b) (42 U.S.C. §§ 1396b(a), 1396d(b)). To qualify for FFP, SSA § 1902(a)(2) establishes the required level that a state must contribute toward medical assistance and administration to obtain FFP. Regarding the use of public funds as the state share of financial participation, 42 C.F.R. § 433.51 provides:

- (a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.
- (b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public

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agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

- (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

B. SOCIAL SECURITY ACT § 1903(w)

Section 1903(w) of the Act includes multiple components. Section 1903(w)(1), (2) addresses donations, section 1903(w)(6) addresses scope of state restrictions and section 1903(w)(7) addresses related organizations.

Section 1903(w) of the Act provides:

(1)(A) . . . for purposes of determining the amount to be paid to a State . . . the total amount expended during such fiscal year as medical assistance under the State plan . . . shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

- (i) from provider-related donations (as defined in paragraph (2)(A)), other than—

- (I) bona fide provider-related donations (as defined in paragraph (2)(B))

. . . .

(2)(A) In this subsection (except as provided in paragraph (6)), the term **“provider-related donation” means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—**

- (i) a health care provider (as defined in paragraph (7)(B)),

- (ii) **an entity related to a health care provider (as defined in paragraph (7)(C)), or**

- (iii) an entity providing goods or services under the State plan for which payment is made to the State

(B) For purposes of paragraph (1)(A)(i)(I), the term **“bona fide provider-related donation” means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary.** The Secretary may by regulation

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specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

....

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

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

(7) For purposes of this subsection:

....

(B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.

(C) **An entity is considered to be "related" to a health care provider if the entity—**

(i) **is an organization**, association, corporation or partnership formed by or **on behalf of health care providers;**

(ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;

(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

(iv) **has a similar, close relationship (as defined in regulations) to the provider.**¹

SSA §§ 1903(w)(1), (2), (6), (7) (emphasis added).

¹ See also 42 C.F.R. § 433.52, which provides similar language in defining the term "provider-related donation" and 42 C.F.R. § 433.54, which defines bona fide donations.

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C. 42 C.F.R. § 433.57 — GENERAL RULES REGARDING REVENUES FROM PROVIDER-RELATED DONATIONS AND HEALTH CARE-RELATED TAXES

The regulation at 42 C.F.R. § 433.57 provides:

Effective January 1, 1992, CMS will deduct from a State's expenditures for medical assistance, before calculating FFP, funds from provider-related donations and revenues generated by health care-related taxes received by a State or unit of local government, in accordance with the requirements, conditions, and limitations of this subpart, if the donations and taxes are not—

- (a) Permissible provider-related donations, as specified in § 433.66(b); or
- (b) Health care-related taxes, as specified in § 433.68(b).

42 C.F.R. § 433.66(b) specifies that permissible provider-related donations include bona fide donations as defined in § 433.54.² Section 433.54(a) of the regulation defines a bona fide donation as a provider-related donation made to the state or unit of local government that has no direct or indirect relationship to Medicaid payments made to a health care provider or any related entity providing health care items and services.

V. SUBSTANTIVE STATE LEGAL AUTHORITY — SETOFF DEBT COLLECTION PROGRAM

In 1995, the South Carolina legislature established the Setoff Debt Collection Program. *See* SC CODE § 12-56-10 et seq. Under the program, when a state agency, board, political subdivision or other governmental or quasi-governmental entity (*id.* § 12-56-20(1) (definition of claimant agency)) is owed a delinquent debt, the governmental entity may request that the South Carolina Department of Revenue setoff payment of that debt from any tax refund that the debtor would otherwise be entitled to receive. SC CODE § 12-56-50; GHA Amicus Brief at 6. The program, in essence, garnishes state tax returns of individuals who owe money to the governmental entity. *See* SCDHHS Exhibit 9 at 5; SCDHHS Exhibit 18 at 1; CMS Brief at 3. “Subject to certain limitations, the South Carolina Department of Revenue will then pay to the governmental entity, on behalf of the individual debtor, part or all of the individual’s debt to that governmental entity by ‘setting off any refunds due the debtor from the department by the sum’ of the delinquent debt.” SCDHHS Pre-Hearing Brief at 5-6, 16; GHA Amicus Brief at 6, 21; Prisma Health Amicus Brief at 12-13; SC CODE § 12-56-50.

² Unrelated to this case, the regulations also specify that permissible provider-related donations may include donations made by a hospital, clinic or similar entity to cover direct costs of personnel whose purpose is to determine Medicaid eligibility or provide Medicaid outreach services. 42 C.F.R. § 433.66(b)(2).

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VI. FACTUAL BACKGROUND

A. BACKGROUND — CURRENT RELATIONSHIP BETWEEN AMICI CURIAE PRISMA HEALTH AND THE GREENVILLE HEALTH AUTHORITY

Greenville Health System, now known as the Greenville Health Authority (GHA), was established by the South Carolina Legislature in 1947 and is tasked with ensuring “the establishment and maintenance of adequate health care facilities in the community it serves.”³ GHA Amicus Brief at 1. Prior to 2016, GHA owned and operated Greenville Memorial Hospital (now Prisma Health Greenville Memorial Hospital (PHGMH)). *Id.* at 2. In 2016, GHA entered into a long-term lease with a private operator, which eventually became Prisma Health (Prisma), that directly administers the hospital on behalf of GHA. GHA Amicus Brief at 2 n.1. GHA continues to exist as a distinct entity that owns the hospital. *Id.* Amicus Prisma Health currently operates both PHGMH and PHRH.⁴ SCDHHS Pre-Hearing Brief at 1; CMS Brief at 3.

Significantly, both hospitals have a long history of serving needy patients in South Carolina and are closely affiliated with the University of South Carolina School of Medicine Greenville and train medical residents and medical students through that affiliation.⁵ *See* Prisma Health Amicus Brief at 4-5; Prisma Health Revised Petition to Participate as a Party in Reconsideration Hearing for South Carolina SPAs at 3.

B. SPA SUBMISSION

The disapproved SPAs involve South Carolina’s Medicaid program, which pays a supplemental payment (in addition to the regular Medicaid payment) to practitioners who are affiliated with state university teaching programs that train medical residents and interns. SCDHHS Pre-Hearing Brief at 3. These payments help support state training programs and ensure robust participation from specialists and primary care providers in serving Medicaid patients. *Id.*

“South Carolina’s program, which began in 2001, targets physicians who are employed by or under contract with South Carolina Medical Universities and their component units. In March 2016, [South Carolina Department of Health and Human Services (SCDHHS)] submitted a state plan

³ GHA explains that while its enabling legislation has been amended and its name has changed numerous times over the years, its basic statutory service remains essentially the same. GHA Amicus Brief at 2, 17.

⁴ The Presiding Officer notes that CMS’ July 9, 2019 SPA denial referred to PHGMH and PHRH by their former names, Greenville Memorial Hospital and Palmetto Health Richland. SCDHHS Exhibit 18. The relationship between GHA, Prisma Health and their institutional evolution is further explained in section VI.A, *infra*.

⁵ PHGMH’s history dates back to City Hospital in Greenville, which was opened in 1912. Greenville Memorial Hospital was owned and operated by the Greenville General Hospital Board of Trustees (which became Greenville Health System and is now known as the Greenville Health Authority) from 1948 until 2016. GHA Amicus Brief at 1; Prisma Health Amicus Brief at 11. PHRH’s history dates back to Columbia Hospital, established in 1892, and which was later renamed Richland Memorial Hospital. Richland Memorial Hospital merged with Baptist Hospital (formerly South Carolina Hospital) in the late 1990s to form Palmetto Health. Prisma Health Amicus Brief at 4. In 2016, Greenville Memorial Hospital was leased to a non-profit organization, which eventually merged with Palmetto Health in 2017 to form Prisma Health. Prisma Health Amicus Brief at 5; SCDHHS Pre-Hearing Brief at 4-5.

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amendment (SPA 16-0004) to change the calculation of these payments from a percentage of Medicaid charges to a payment based on the ‘average commercial rate.’” *Id.* at 3-4.

SPA 16-0004 identified eight institutions whose teaching physician providers would qualify for supplemental payments. The list included physicians employed by or under contract with Greenville Memorial Hospital. At the time SPA 16-0004 was submitted, Greenville Memorial was operated by GHA. *See id.* at 4. South Carolina informed CMS that the source of the non-federal share of the supplemental payments described in SPA 16-0004 would come from intergovernmental transfers (IGTs) from public entities. CMS approved the SPA, with a “sunset” date of September 30, 2016. *Id.*

SCDHHS then submitted SPA 16-0012 to extend the supplemental payment program for the period beginning October 1, 2016. Notably, the SPA indicated that the state share of the physician supplemental payments for these two hospitals comes from purported IGTs from GHA to South Carolina, funded primarily from the Setoff Debt Collection Program. SCDHHS Exhibit 9. The SPAs proposed that CMS would pay the corresponding FFP for the physician payments. *Id.*; CMS Brief at 3.

Although GHA still owned the hospital, as of October 1, 2016, GHA leased its assets to a private non-profit (now Prisma Health), which assumed substantially all of the obligations of GHA, including operation of Greenville Memorial Hospital. Prisma Health Amicus Brief at 5. This raised CMS’ concern relating to the transfers of funds from GHA as the non-federal share of supplemental payments. Accordingly, CMS and SCDHHS agreed that payments to physicians associated with Greenville Memorial Hospital would be submitted as a separate SPA so as not to affect approval for the remaining hospitals. SCDHHS Pre-Hearing Brief at 4-5. At CMS’ request, the State separated SPA 16-0012 into two pieces. SPA 16-0012 included all participating hospitals with the exception of Greenville Memorial Hospital and SPA 16-0012-A included only Greenville Memorial Hospital. CMS promptly approved SPA 16-0012, and issued a “request for additional information” regarding SPA 16-0012-A. *Id.* at 4; SCDHHS Exhibit 5.

When GHA later merged with Palmetto Health (the parent corporation of Palmetto Health Richland Hospital or PHRH), forming Prisma Health, CMS raised similar concerns with respect to transfers from GHA being used as the non-federal share of payments to PHRH. Thus, when subsequent SPAs 17-0006 and 18-0011 were submitted, they did not include physicians affiliated with these two hospitals, whereas SPA 17-0006-A and 18-0011-A included such physicians. *See* SCDHHS Exhibits 6, 7, 10, 11. CMS has approved SPA 17-0006 and approval of SPA 18-0011 was pending when the parties submitted briefs for this appeal. SCDHHS Pre-Hearing Brief at 5.

From the time SPA 16-0012-A was submitted in March 2017 until the three SPAs at issue (16-0012-A, 17-0006-A and 18-0011-A) were disapproved in July 2019, SCDHHS provided information to CMS regarding the validity of the funding source for the payments to physicians affiliated with Greenville Memorial Hospital and Palmetto Health Richland. In January 2018, Jeff Saxon of SCDHHS forwarded to CMS a lengthy description of the legal status of GHA, as well as an explanation of the Department of Revenue’s Setoff Debt Collection Program from which the majority of funds would be derived, to explain why SCDHHS had concluded that the

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funds were a valid IGT. *See* SCDHHS Exhibit 9. CMS responded that it “do[es] not have an issue with the entity” transferring the funds, but believed that “1903(w)(6)(A) of the statute requires that IGTs must be derived from state or local tax revenue.” *Id.*

In January 2019, the Director of SCDHHS sent a memo to CMS explaining the public status of GHA, describing the legal authorities supporting SCDHSS’ position that IGTs did not have to come from state or local taxes, and assuring that “[the Greenville Health Authority] will not have any financial gain as result of the transfers,” and that “[t]here are no provider-related donations between’ the two hospitals and Greenville Health Authority.” SCDHHS Pre-Hearing Brief at 6.⁶

In April 2019, SCDHHS provided responses to CMS’ requests for additional information for SPA 16-0012-A, indicating that GHA was a public entity and explaining that the Setoff Debt Collection funds were funds collected by the South Carolina Department of Revenue for debts owed to Greenville Memorial Hospital from the time period when it was owned and operated by GHA, and therefore a valid source of public funds. SCDHHS Exhibits 14, 15. In May 2019, SCDHHS provided similar responses with respect to the requests for additional information for SPAs 17-0006-A and 18-0011-A. SCDHHS Exhibits 16, 17.

On July 9, 2019, CMS disapproved the three SPAs, concluding that GHA’s revenue transfer to the State Medicaid Agency violated § 1903(w)(6)(A) of the Act. SCDHHS Exhibit 18. CMS’ basis for disapproval was that the ultimate source of the revenue was not derived from state or local tax revenue, but rather, from uncollected patient revenues which were directly garnished from state individual income tax refunds. CMS found that GHA does not have taxing authority nor does it receive appropriated funds that could be used as the source of the non-federal share for an allowable intergovernmental transfer. *Id.* CMS disapproved the SPAs because the non-federal share of the payments proposed therein would not originate from a permissible source. *Id.* CMS stated:

These amendments propose to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland to the current physician teaching supplemental payment methodology. I regret to inform you that I am unable to approve SPAs 16-0012-A, 17-0006-A, and 18-0011-A as the state has proposed to fund the non-federal share of payments in a manner that is not consistent with sections 1902(a)(2), 1903(a), 1903(w)(6)(A), and 1905(b) of the Social Security Act (the Act).

The payments proposed under the SPAs would be funded through amounts transferred from the Greenville Health Authority (GHA) to

⁶ The Presiding Officer notes that SCDHHS Exhibit 13 states:

Importantly, GHA will not have any financial gain as a result of the transfers. These transfers will entirely support Medicaid payments to the Upstate Affiliate Organization (dba Greenville Health System), not the GHA. There are no provider-related donations between the Upstate Affiliate Organization (dba Greenville Health System) and GHA. The GHA transfers will not be replenished in any way by the Upstate Affiliate Organization (dba Greenville Health System).

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the State Medicaid Agency. The state contends that GHA is a unit of government that supports providers within the Greenville Health System and Palmetto Health System (since merged into a single entity – Prisma Health). Section 1903(w)(6)(A) of the Act allows units of government to participate in Medicaid funding through an intergovernmental transfer (IGT) derived from state or local taxes and transferred to the other State Medicaid Agency as the non-federal share of Medicaid payments. While CMS has not examined or concluded whether GHA is a unit of government eligible to fund the non-federal share of the proposed payments, the source of GHA's transfers would be from a "Setoff Debt Collection Program," rather than state or local tax revenue as required by the statute for an IGT.⁷ Therefore, the proposed IGTs would not be consistent with the Medicaid statute.

The "Setoff Debt Collection Program" garnishes state individual income tax refunds to satisfy outstanding liabilities (medical debt) owed for services provided at certain providers. The revenue collected through the Setoff Debt Collection Program is not derived from state or local taxes as required by the statute to support an IGT, but instead from previously uncollected patient revenue. As such, the revenue is not a permissible source that may be used for IGTs to serve as the non-federal share of the supplemental payments under the proposed SPAs. In addition, GHA does not have taxing authority or otherwise directly receive appropriated funds that could be used as the source of non-federal share for the proposed payments as an allowable IGT.

Section 1902(a)(2) of the Act provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Sections 1903(a) and 1905(b) of the Act provide that states received a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance. States must use a permissible source of the non-federal share of payments for state expenditures on medical assistance in order to receive the statutorily determined FMAP. Without a permissible funding source for the non-federal share of Medicaid payments, a state's expenditures do not qualify to be matched with federal funds. Under such circumstances, the state would not receive any statutorily determined FMAP. The non-federal share of the

⁷ CMS did not challenge whether GHA is a unit of local government eligible to fund the non-federal share of the proposed payments. CMS Brief at 2-3.

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payments proposed in SPAs SC-16-0012-A, SC-17-0006-A, and SC-18-0011-A would not originate from a permissible source, and the state has not proposed a permissible alternative to fund the proposed payments. Without a permissible source of the non-federal share of payments, CMS cannot approve the SPAs consistent with the foregoing provisions of the Act.

SCDHHS Exhibit 18 at 1-2.

The State sought reconsideration of the disapproval by letter dated September 5, 2019. SCDHHS Exhibit 22. The CMS Administrator issued a notice, which was published in the Federal Register on October 11, 2019, announcing a hearing to reconsider CMS' decision to disapprove the state plan amendments. SCDHHS Exhibit 23. In addition to reiterating CMS' position as outlined in the July 9, 2019 denial notice, the Federal Register notice also indicated that the issues to be considered at the hearing were whether the three SPAs were inconsistent with the requirements of:

Section 1902(a)(2) of the Act, which provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services under the plan.

Sections 1903(a) and 1905(b) of the Act, which provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.

Section 1903(w)(6)(A) of the Act, which allows states to use funds derived from state or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under section 1903 of the Act.⁸

VII. APPEAL PROCEDURAL HISTORY: BRIEFING/DISCOVERY/HEARING

On October 25, 2019, the Presiding Officer received two Petitions to Participate as a Party in these reconsideration proceedings: one from Prisma Health and one from Greenville Health Authority. CMS filed objections to both requests on November 4, 2019. On January 16, 2020,

⁸ CMS indicates that sections 1902(a)(2), 1903(a) and 1905(b) of the Social Security Act were cited in the July 9, 2019 disapproval to generally indicate that FFP is only available to match Medicaid expenditures with permissible sources of state share. CMS reiterates that its core concern is that the alleged provider donation from GHA is not a permissible source of the state share. CMS Brief at 17.

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the Presiding Officer issued two orders finding that neither Prisma Health nor Greenville Health Authority had met its burden in showing, by a preponderance of the evidence, that its stated interests in these proceedings fall within the zone of interests to be protected by the governing Federal statute as required by 42 C.F.R. § 430.76(b)(1). As a result, both Petitions to Participate as a party were denied, but the Presiding Officer found that each entity met the criteria set forth in 42 C.F.R. § 430.76(c) to participate as an amicus curiae, which CMS did not oppose.

On January 23, 2020, the Presiding Officer and the parties conducted a telephonic conference. On January 29, a briefing schedule was distributed to the parties and both amicus curiae setting forth briefing deadlines and a June 23, 2020 hearing date. The State and both amici submitted briefs with exhibits on March 5, 2020. CMS filed its brief with exhibits on May 19, 2020. Shortly thereafter, the parties expressed that a live hearing would not be necessary and agreed to conduct these proceedings on the record. Finally, the State submitted its optional reply on June 8, 2020 (with a revised version making technical adjustments on June 11, 2020) and additional evidentiary material on September 17, 2020.

VIII. DISCUSSION: FINDINGS OF FACT AND CONCLUSIONS OF LAW

CMS correctly determined the South Carolina's SPAs were not approvable. The Presiding Officer finds that based upon the close relationship between GHA and the Prisma hospitals, PHGMH and PHRH, the funds meet the statutory definition of non-bona fide donations, which are not a permissible funding source for the non-federal share of Medicaid payments.

In review, the disapproved SPAs involve supplemental payments to physicians who are affiliated with state university teaching programs that train medical residents and interns. CMS does not object to this type of payment, or how it was calculated, but questions the source of the non-federal share of the payments made to physicians affiliated with PHGMH and PHRH. CMS Brief at 1, 3. To fund the supplemental teaching physician payment program, the state collects money on behalf of GHA via the Setoff Debt Collection Program. This program allows the state to garnish state individual income tax refunds to satisfy outstanding liabilities (medical bills owed to GHA related to medical services provided by GHA on or before September 30, 2016). SCDHHS Exhibit 9 at 4. The SPAs propose that GHA would transfer these funds to the South Carolina Medicaid program, which would use such funds for the non-federal share of physician supplemental payments and CMS would pay the corresponding FFP. CMS Brief at 3; GHA Amicus Brief at 6, 8; SCDHHS Exhibit 9.

CMS contends that the revenue collected on behalf of GHA through the Setoff Debt Collection Program was derived from services provided when it operated Greenville Hospital. As such, it falls within the section 1903(w)(1)(A) statutory definition of a non-bona fide provider donation, which must be deducted from the total amount of expenditures eligible for FFP; it is not a permissible funding source for the non-federal share of Medicaid payments and would only be protected against this deduction if it was a protected IGT pursuant to section 1903(w)(6) of the Act. CMS determined that the proposed payments were not protected IGTs as they were not derived from state or local tax revenues or qualifying appropriations.

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Procedurally, SCDHHS objects to CMS presenting any argument related to the IGTs being an impermissible donation, arguing that it:

is not an issue identified for the hearing, *see* SC Ex. 23; the disapproval letter does not take the position that the transferred funds would be a donation subject to the restrictions in Section 1903(w)(1); *see* SC Ex. 18; the Requests for Additional Information (“RAIs”) sent by CMS in the course of the SPA review process do not mention Section 1903(w)(1) or raise any concern that the transferred funds would be donations, *see* SC Exs. 5, 8, 12; nor was there any informal discussions in which CMS suggested that the transferred funds could be considered donations.

SCDHHS Reply Brief at 2.

The Presiding Officer rejects the SCDHHS’ view that the scope of this proceeding may not include CMS’ arguments related to impermissible donations. First, the Presiding Officer notes that the third listed issue in this reconsideration proceeding includes whether the SPAs are inconsistent with:

Section 1903(w)(6)(A) of the Act, which allows states to use funds derived from state or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments **unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under section 1903 of the Act.**

SCDHHS Exhibit 23 (emphasis added).

The Presiding Officer finds that section 1903(w)(6)(A) of the Act contains a restriction relating to taxes and other qualified appropriations. The section also discusses, and was intended to cover, concerns relating to intergovernmental transfers as a whole.⁹ Notably, the provision expressly discusses “donations,” which is covered within section 1903(w) of the Act. Furthermore, the Presiding Officer finds that the State was on notice of CMS’ concern with regard to whether the IGTs were provider-related donations as early as 2017, when Greenville Health System’s Chief Financial Officer briefed Jeff Saxon with SCDHHS on the issue, noting that a “CMS Email attempt[ed] to characterize the IGT Funds made by the Greenville Health Authority as ‘donations that would not otherwise be recognized as the non-Federal share. . . .’” SCDHHS Exhibit 9 at 5. Section 1903(w)(6)(A) provides:

⁹ It is undisputed that the source of the funds in question are uncollected payments for services, as opposed to state or local taxes or appropriations to the hospital. *See* CMS Brief at 2; SCDHHS Pre-Hearing Brief at 2; SCDHHS Reply Brief at 7.

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

SSA § 1903(w)(6)(A) (emphasis added).

With regard to the substantive arguments made by CMS, the Presiding Officer finds that CMS' position is supportable. Section 1903(w)(1)(A) reduces provider related donations (other than bona fide donations) for purposes of determining the amount to be paid to a state. In review, the phrase "provider related donation" is defined in section 1903(w)(2)(A) as follows:

In this subsection (except as provided in paragraph (6)), the term "provider-related donation" means any donation or other voluntary payment **(whether in cash or in kind) made (directly or indirectly)** to a State or unit of local government by—

- (i) a health care provider (as defined in paragraph (7)(B)),
- (ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or**
- (iii) an entity providing goods or services under the State plan for which payment is made to the State

The terms "related" and "health care provider" are also further defined under section 1903(w)(7). That section states:

For purposes of this subsection:

. . . .

(B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.

(C) An entity is considered to be "related" to a health care provider if the entity—

- (i) is an organization,** association, corporation or partnership formed by or **on behalf of health care providers;**

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- (ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;
- (iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or
- (iv) **has a similar, close relationship (as defined in regulations) to the provider.**¹⁰

Social Security Act § 1903(w)(7) (emphasis added).

Applying the statutory definition, the Presiding Officer finds GHA and the two hospitals are closely related. It is undisputed that GHA was originally established on behalf of and continues to support health care providers. GHA is tasked with ensuring the “the establishment and maintenance of adequate health care facilities in the community it serves.” GHA Amicus Brief at 1. Amicus Prisma Health, a private operator, administers both PHRH and PHGMH. SCDHHS Pre-Hearing Brief at 1; CMS Brief at 3. As GHA also represents:

Greenville Hospital was both owned and operated by GHA prior to 2016. Although GHA no longer operates Greenville Hospital, GHA continues to exist as a distinct governmental entity that owns the facility, and GHA continues to discharge various statutory functions related to the Hospital, including overseeing the leasing arrangement with the Hospital’s operator to ensure adequate operations and maintenance of hospital services in Greenville County. In short, GHA exists in large measure to ensure Greenville Hospital’s continued financial and operation viability for the benefit of the upstate South Carolina community. Consequently, GHA has a strong interest in the proper resolution of this matter with respect to all of the Disapproved SPAs.

GHA Amicus Brief at 3 (footnotes omitted).

Accordingly, the Presiding Officer finds that CMS was justified in classifying the transfer of funds under examination as a “donation” in accordance with the controlling statutory definition.

Next, the Presiding Officer notes that section 1903(w)(1)(A)(i)(I) of the Act contains an exception regarding the treatment of bona fide donations, which do not reduce the amount to be paid to a state the way provider donations do. Section (w)(1)(B) defines a bona fide donation as follows:

For purposes of paragraph (1)(A)(i)(I), the term “bona fide provider-related donation” means a provider-related donation **that has no direct or indirect relationship (as determined by the Secretary) to payments** made under this title to that provider, to providers

¹⁰ See also 42 C.F.R. § 433.52, which defines the term “provider related donation.”

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furnishing the same class of items and services as that provider, **or to any related entity**, as established by the State to **the satisfaction of the Secretary**. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.¹¹

SSA § 1903(w)(1)(B) (emphasis added).

As noted above, SCDHHS presents a procedural objection with regard to CMS making any argument related to the IGTs being an impermissible donation. The State briefly discusses its position that the IGTs would not even be considered provider-related donations, arguing:

A donation must be “provider-related” in order to implicate Section 1903(w)(1). A “provider-related donation” is defined as one “made directly or indirectly to a State or unit of local government by or on behalf of a health care provider. . . .” 42 C.F.R. § 433.52. A “health care provider” is an entity “that receives payment or payments for health care items or services provided.” *Id.* Greenville Health Authority (“GHA”) is not a health care provider, and the transferred funds at issue do not come from health care providers. Rather, as set forth more fully in the amicus brief of the Authority, the funds come from the South Carolina Department of Revenue, which collects them from tax refunds otherwise payable to individuals, representing amounts that those individuals owed to the hospitals that GHA previously operated. Moreover, even if GHA were a health care provider, CMS has not treated transfers of funds from public providers as donations as long as the funds are “public funds.”

SCDHHS Reply Brief at 3 n.1.

The Presiding Officer finds, however, that the transfer of funds would not expressly qualify as a bona fide donation as the transfer has a relationship to (uncollected) payment for services. Additionally, as noted above, GHA and the two hospitals at issue are related entities. Further, the Presiding Officer notes that the statute provides that the Secretary retains a high level of discretion over whether the donation is bona fide.

SCDHHS notes that the regulations at 42 C.F.R. §§ 433.51(b) and 433.57 permit “public funds” that are transferred from other public agencies to be considered as the non-federal share in claiming FFP, as long as those funds do not come from impermissible provider taxes or non-bona fide donations. SCDHHS Pre-Hearing Brief at 2. While the regulations address when public funds “may” be considered as the state share, they do not overcome the Social Security Act’s restriction in section 1902(w) of the use of non-bona fide donations as a permissible source of the non-federal

¹¹ See 42 C.F.R. § 433.54, which defines bona fide donations and § 433.66, which defines permissible provider-related donations.

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share of payments for state expenditures. In this case, as the funds are derived from non-bona fide donations, as discussed above, 42 C.F.R. § 433.51(b) would not permit the funds in question, regardless of whether they qualify as public funds, to be considered for the non-federal share.¹²

IX. PROPOSED DECISION

The Presiding Officer recommends that the CMS Administrator uphold the July 9, 2019 disapproval of SCDHHS' SPAs 16-0012-A, 17-0006-A and 18-0011-A. Based upon review of the administrative record, South Carolina failed to prove that the SPAs conform with federal requirements. *See* 42 C.F.R. § 430.3.

Benjamin R. Cohen, Esq.
Presiding Officer

Date: December 23, 2021

¹² While SCDHHS indicates that the monies in questions are public funds, CMS does not concede such point. CMS Brief at 14-15, 17. As the Presiding Officer finds that the monies are provider donations, it does not reach the question regarding whether the funds are "public funds."