

**Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division**

Illinois Department of Healthcare and Family Services
Docket Nos. A-17-33 and A-17-34
Decision No. 2863
April 2, 2018

DECISION

The Illinois Department of Healthcare and Family Services (Illinois) appealed two decisions by the Centers for Medicare & Medicaid Services (CMS) disallowing federal financial participation (FFP) in disproportionate share hospital (DSH) payments that Illinois made under the Medicaid program. CMS disallowed \$4,516,112 FFP in DSH payments to Mount Sinai Hospital of Chicago (Mount Sinai) and \$140,281,912 FFP in DSH payments to the University of Illinois at Chicago Hospital (UIC) for state fiscal years (SFYs) 1997 through 2000. The disallowed amounts represent the difference between the federal share of DSH payments made to the hospitals and the amounts that CMS determined would have been claimed if Illinois had calculated the hospital-specific DSH limits according to federal requirements and Illinois' Medicaid State plan.

For the reasons discussed below, we sustain the disallowances. We conclude that the process that Illinois used to calculate and apply the hospital-specific DSH limits did not follow the standards and methodologies in Illinois' Medicaid State plan. We also conclude that the State plan required Illinois to reconcile estimated DSH payments to actual costs, and Illinois' interpretation of the State plan language to the contrary is unreasonable and not entitled to deference. We further explain that Illinois' additional arguments do not provide any basis for reversing the disallowances.

Legal Background

1. Federal funding under approved Medicaid state plans

The Medicaid program, established under title XIX of the Social Security Act (Act),¹ provides health coverage to qualified individuals with low incomes or disabilities. Act §§ 1901, 1902; 42 C.F.R. Parts 435, 436. The federal government and states jointly finance Medicaid. Act §§ 1901, 1903; 42 C.F.R. Part 430.

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

Each state administers its own Medicaid program under broad federal requirements and the terms of its “plan for medical assistance” (state plan), which must be approved by CMS on behalf of the Secretary of the Department of Health and Human Services. Act § 1902; 42 C.F.R. Part 430. The state “plan is a comprehensive written statement” that describes “the nature and scope” of the state’s Medicaid program and gives “assurance that it will be administered in conformity with the specific requirements of title XIX,” the regulations implementing that title, and other “applicable official issuances” of the Secretary. 42 C.F.R. § 430.10. The state plan sets out, among other things, the state’s methodologies for calculating payments to hospitals.

State plans must be amended as necessary to take into account “[c]hanges in Federal law, regulations, policy interpretations, or court decisions....” 42 C.F.R. § 430.12(c)(1)(i). CMS reviews proposed state plan amendments to “determine whether the plan continues to meet the requirements for approval” and “[t]o ensure the availability of FFP....” 42 C.F.R. § 430.12(c)(2). Once the state plan is approved, the state becomes entitled to receive FFP claimed under its terms as the federal government’s share of a state’s allowable Medicaid expenditures. Act § 1903; 42 C.F.R. § 400.203.

2. *Medicaid DSH payments and hospital-specific limits*

A state pays for hospital services based on payment rates that are determined in accordance with its state plan. Act § 1902(a)(13); 42 C.F.R. §§ 447.252(b), 447.253(i). In setting rates, a state must “take into account” the “situation of hospitals which serve a disproportionate number of low-income patients with special needs[.]” Act § 1902(a)(13)(A)(iv). Congress enacted this provision in 1981, in response to a “finding that ‘public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement,’ have high levels of uncompensated care costs, and therefore need additional financial support in order to continue providing care to the needy.” *Va. Dep’t of Med. Assistance Servs.*, DAB No. 2084, at 3 (2007), *aff’d*, *Va. Dep’t of Med. Assistance Servs. v. Johnson*, 609 F. Supp. 2d 1 (D.D.C. 2009), *quoting* H.R. Conf. Rep. 97-208, at 962 (1981), *reprinted in* 1981 U.S.C.C.A.N. 1010, 1324.

Section 1923 of the Act establishes detailed requirements relating to DSH payments. Relevant in this case, the Omnibus Budget Reconciliation Act (OBRA) of 1993 established hospital-specific limits on DSH payments at section 1923(g) of the Act. Pub. L. No. 103-66, 107 Stat. 312 (1993). The history of the legislation shows that Congress established the limits in reaction to reports that some states were making DSH payments that exceeded the hospitals’ costs of providing medical care to the indigent and using the funds for other purposes. H.R. Rep. No. 103-111, at 211-12 (1993), *reprinted in* 1993 U.S.C.C.A.N. 378, 538-39.

As enacted, section 1923(g) of the Act provides in relevant part that annual DSH payments to each qualifying hospital may not exceed—

the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

3. *The August 1994 CMS letter to state Medicaid directors*

In August 1994, CMS issued a letter to all state Medicaid directors (SMDL) that set forth CMS’s official interpretation of the 1993 DSH legislation.² Illinois Exhibit (IL Ex.) 1. The SMDL described the hospital-specific limit as “composed of two parts.” *Id.* at 3. The first part, the SMDL said, is the “Medicaid shortfall,” which consists of the “cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payment method under the State plan.” *Id.* The second part, the SMDL stated, is “the cost of services provided to patients who have no health insurance or source of third party payment for services provided during the year, less the amount of payments made by these patients.” *Id.*

The SMDL also addressed what types of costs a state may include in the calculation: “First,” CMS said, “the legislative history of this provision makes it clear that States may include both inpatient and outpatient costs in the calculation of the limit.” *Id.* “Second,” CMS stated, “in defining ‘costs of services’” under section 1923(g) of the Act, a state could “use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement.” *Id.* “The Medicare principles,” CMS continued, “are the general upper payment limit [UPL] under institutional payment under the Medicaid program.”³ *Id.* This interpretation of “costs incurred,” CMS stated, was “reasonable because it provides States with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs.” *Id.* at 3-4.

² At that time, the federal agency that administered the Medicare and Medicaid programs was known as the Health Care Financing Administration. For ease of reading, we refer to the federal agency as CMS.

³ A state’s Medicaid payments for services furnished by specific groups of hospitals and other providers may not exceed Medicaid “upper payment limits.” Act § 1902(a)(30); 42 C.F.R. §§ 447.250(b), 447.253(b)(2), 447.272. An aggregated upper payment limit applies to each of the following groups: state government-owned or -operated providers; non-state government-owned or -operated facilities; and privately-owned and -operated facilities. 42 C.F.R. § 447.272(a). For each group, the upper payment limit is an aggregate, “reasonable estimate of the amount that would be paid for the services furnished by the group . . . under Medicare payment principles[.]” *Id.* § 447.272(b)(1).

Lastly, the SMDL instructed states to take several steps to implement the hospital-specific limit by September 30, 1994. One such step, the SMDL stated, would be to submit, if necessary, a state plan amendment designed to bring DSH payments in line with the limit. *Id.* at 5-6.

Illinois' State plan⁴

During the audit period, the parties agree, Illinois' State plan provided for DSH payments to be made to qualified acute care hospitals as an add-on to the hospitals' regular per diem rates for individual Medicaid inpatient admissions. IL Ex. 2, at 46-52, 120; *see also* IL Ex. 3, ¶ 3. Illinois annually determined each hospital's DSH add-on amount for the coming rate year, based on Medicaid inpatient utilization rates and other criteria set forth in the State plan. *Id.* The rate year ran from October 1 through September 30, and Illinois notified hospitals of their inpatient payment rates, including DSH add-on amounts, prior to the October 1 start of the coming rate year. IL Ex. 3, ¶ 3.

To implement the hospital-specific DSH limit legislation, Illinois submitted, and CMS approved, the following State plan amendment:

In accordance with Public Law 103-66, adjustments to individual hospital's disproportionate share payments shall be made if the sum of Medicaid payments (inpatient, outpatient, and disproportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. The adjustment to hospitals will be computed by determining a hospital's cost of inpatient and outpatient services furnished to Medicaid patients, less the amount paid to the hospital for inpatient and outpatient services excluding DSH payments made under this State plan. The cost of services provided to patients who have no health insurance or source of third-party payment less any payments made by these patients shall be determined and added to the Medicaid shortfall calculated above. The result shall be compared to the hospital's estimated DSH payments. If the estimated DSH payments exceed the DSH limit (Medicaid shortfall plus cost of uninsured) then the Department will reduce the hospital's DSH rate per day so that their DSH payments will equal the DSH limit. If necessary, retroactive adjustments will be made.

IL Ex. 2, at 53.

⁴ The relevant sections of Illinois' Medicaid State plan are contained in Illinois Exhibit 2. The citations in this decision refer to the internal page numbers of State plan "Attachment 4.19-A."

The State plan also imposed “reporting” requirements on hospitals. *Id.* at 57. Specifically, “on or before August 15, of the rate year,” each hospital was required to report “the following information separated by inpatient and outpatient”: (1) “The dollar amount of [its] uncompensated care charges rendered in the base year”; (2) “The dollar amount of charges rendered in the base year that are reimbursable by the Department for those . . . covered under the Family and Children Assistance Program . . .”; (3) “The dollar amount of Medicaid charges rendered in the base year”; and (4) “The dollar amount of total charges for care rendered in the base year.” *Id.*

The State plan defined “DSH determination year” to mean “the 12 month period beginning on October 1 of the year and ending September 30 of the following year.” *Id.* at 53. The State plan provided, “[b]ase fiscal year’ means, for example, the hospital’s fiscal year ending in 1991 for the October 1, 1993, DSH determination year, the hospital’s fiscal year ending in 1992 for the October 1, 1994, DSH determination year, etc.” *Id.*

Case History

1. Office of Inspector General (OIG) audits of Illinois’ DSH payments to UIC and Mount Sinai

In 2004, the OIG for the Department of Health and Human Services completed audits of Illinois’ Medicaid DSH payments to UIC and Mount Sinai for SFYs 1997 through 2000. IL Exs. 7 and 8.⁵ The OIG reported that Illinois had determined the DSH add-on amount for each hospital for the coming rate year based on a “complex system of tiered rates that generally increase as Medicaid inpatient utilization increases[,]” not uncompensated care costs. IL Ex. 7, at 1; IL Ex. 8, at 1.

The OIG further reported that Illinois had prospectively calculated each hospital’s DSH limit for the coming rate year by combining estimated Medicaid inpatient costs, estimated Medicaid outpatient costs, and estimated “uncompensated charity care costs.” IL Ex. 7, at 1-2; IL Ex. 8, at 1-2. Illinois estimated Medicaid inpatient costs using cost figures from SFY 1992 hospital patient discharges, adjusted for inflation and case mix factors, and applied to the number of estimated hospital discharges for each year from 1997 through 2000. IL Ex. 7, at 4; IL Ex. 8, at 4. For outpatient costs, Illinois used SFY “1994 outpatient charges subject to further adjustment and factoring.” *Id.* Illinois computed “uncompensated charity care costs” using uncompensated care charges reported by each hospital on a State-designed “OBRA 1993 Data Collection Form” for

⁵ The OIG audit reports are contained in Illinois Exhibits 7 and 8. The citations in this decision use the reports’ internal page numbers.

the second preceding fiscal year, inflated and adjusted using the hospital's cost-to-charge ratio for the third preceding year. IL Ex. 7, at 4-5; IL Ex. 8, at 4-5. For each hospital, Illinois then "compared the total estimated Medicaid inpatient, outpatient, and uncompensated charity care costs with the budgeted Medicaid liability" for the coming year. IL Ex. 7, at 2; IL Ex. 8, at 2. "If the budgeted payments were less than the estimated costs, the State concluded that the hospital-specific limit was not exceeded." *Id.*

The OIG determined that Illinois' DSH payments to UIC and Mount Sinai "significantly exceeded" the hospital-specific DSH limits. IL Ex. 7, at 3; IL Ex. 8, at 3. Specifically, the OIG concluded, Illinois' combined payments to UIC exceeded UIC's actual costs of providing inpatient and outpatient services to Medicaid and uninsured patients by \$280.6 million (\$140.3 million federal share). IL Ex. 7, at 3. Illinois' payments to Mount Sinai, the OIG determined, exceeded Mount Sinai's actual costs of providing inpatient and outpatient services to Medicaid and uninsured patients by about \$9 million (\$4.5 million federal share). IL Ex. 8, at 3.

The OIG calculated the overpayment amounts for each year of the audit period based on summarized cost data collected from UIC and Mount Sinai and summarized payment data provided by Illinois. IL Ex. 7, at 3-4, App. A; IL Ex. 8, at 3-4, App. A. From the Medicaid inpatient and outpatient cost data, the OIG computed cost-to-charge ratios and applied them to the hospitals' "uninsured patient charges (charity care) in order to calculate the costs of providing inpatient and outpatient services to uninsured patients (charity care)." IL Ex. 7, at 3; IL Ex. 8, at 3. "To determine compliance with the hospital-specific limits," the OIG "added Medicaid inpatient costs, Medicaid outpatient costs, and charity care costs and compared the total with total Medicaid inpatient, outpatient and DSH payments to" the hospitals. *Id.*

The OIG concluded that Illinois' DSH payments to UIC and Mount Sinai exceeded the hospital-specific limits because: (1) Illinois did not use actual cost data from the previous year to calculate DSH payments for the next year; (2) Illinois did not compare Medicaid payments (inpatient, outpatient and DSH) with actual Medicaid and charity care costs and make retroactive adjustments to the DSH payments, as required by its State plan and the Illinois Administrative Code; and (3) the hospitals included uncompensated charges for insured patients in their reported uncompensated charity care charges.⁶ IL Ex. 7, at 4-5; IL Ex. 8, at 4-5.

⁶ The OIG conducted an additional review of Illinois' DSH-limit computations for UIC after the OIG received Illinois' comments to the OIG's preliminary report. The OIG found that Illinois had over-inflated its estimates of inpatient costs when it calculated UIC's hospital-specific DSH limits. Under the methodology that Illinois used, the OIG stated, about one-fifth of the 1992 inpatient costs per discharge were to be inflated by a set, five-percent rate per year over the eight-year period from 1992 to 2000. IL Ex. 7, at 7. "Instead," the OIG found, "the State inflated these costs by over 26 percent per year." *Id.* Consequently, the OIG determined that if Illinois had "correctly followed its own methodology, it would have disclosed to CMS that payments to [UIC] were estimated to exceed the hospital-specific limit by about \$39 million for State fiscal year 1996." *Id.*

2. *CMS's initial and reconsidered determinations*

In July 2016, CMS notified Illinois that it was disallowing the federal share of DSH payments to UIC and Mount Sinai identified in the October 2004 OIG audit reports. IL Ex. 10. CMS summarized the scope, findings and recommendations of the audits, including the bases for the OIG's calculations of the overpayments. CMS stated that the OIG recommended that Illinois compare annual Medicaid payments, including DSH payments, to "the actual cost of providing services to Medicaid and uninsured patients for all hospitals receiving DSH payments, and, if applicable, make retroactive adjustments as required by the state plan, including the recovery of any identified overpayments." *Id.* at 1, 5. CMS stated that it concurred with the OIG and adopted its recommendations. CMS additionally cited the 1994 SMDL to support the disallowances.

Illinois timely asked CMS to reconsider the disallowance determinations. In November 2016, CMS notified Illinois that after review and consideration of Illinois' arguments, CMS found no basis to revise or reverse the disallowances. IL Ex. 11. Illinois timely appealed CMS's determinations to the Board.⁷

3. *Illinois' arguments on appeal*

Illinois argues that during the audit period, federal law and its State plan permitted it to use a prospective methodology to estimate the costs incurred by a hospital for purposes of calculating the hospital-specific DSH limits. Moreover, Illinois contends, neither the Act nor its State plan required it to reconcile the DSH payments it made based on estimated costs to the hospitals' actual uncompensated care costs. According to Illinois, federal law did not require a state to reconcile estimated DSH payments to a hospital's actual costs until 2005, and federal law did not treat estimated payments in excess of actual costs as overpayments until 2011. Illinois also argues that neither the Act nor its State plan required it to exclude unpaid charges for insured patients in the calculation of uncompensated care costs. Illinois asserts that CMS has held Illinois' hospitals to a standard different from that applied to other hospitals. In the event that the Board concludes that the Act or Illinois' State plan required it to reconcile and recoup the DSH payments to UIC and Mount Sinai that exceeded actual uncompensated care costs, Illinois says, the Board should overturn the disallowances because they are "untimely and prejudicial." IL Br. at 10 n.4.

⁷ Illinois filed a combined notice of appeal to the Board because the two disallowances were based on the same legal conclusions and to allow the Board to address the common issues through a single proceeding. For administrative purposes, the Board docketed Illinois' appeals under docket numbers A-17-33 and A-17-34, but consolidated the appeals without objection by CMS.

Analysis

1. Introduction

A state is eligible for FFP in its Medicaid DSH payments if the payments are authorized under the Act and calculated according to the standards, methods and procedures set forth in the approved state plan. Act §§ 1901, 1903(a)(1); 42 C.F.R. §§ 430.10, 447.253(i); *Accord Me. Dept. of Health and Human Servs.*, DAB No. 2292, at 10 (2009) (citing authorities), *aff'd*, *Me. Dep't of Health and Human Services v. U.S. Dep't of Health and Human Servs.*, 766 F. Supp. 2d 288 (D. Me. 2011). The Board previously has explained that even if, prior to 2011, a state “had the flexibility” under section 1923(g) of the Act to calculate hospital-specific DSH limits using estimated costs without subsequent reconciliation to actual costs, as Illinois argues in this case, “FFP is available only for DSH payments that are determined according to the methodology” that the state established in its approved Medicaid state plan. *La. Dep't of Health and Hosps.*, DAB No. 2350, at 7 (2010), *aff'd*, *La. Dep't of Health and Hosps. v. U.S. Dep't of Health and Human Servs.*, 566 Fed. App'x 384 (5th Cir. 2014).

Here, we need not resolve whether section 1923(g) of the Act required Illinois to reconcile its DSH payments to actual costs during the audit period because, as discussed below, the process that Illinois used to calculate and apply the hospital-specific DSH limits during the audit period cannot reasonably be considered consistent with the methodology that Illinois established, and CMS approved, in the State plan. Furthermore, we explain, Illinois’ interpretation of the “retroactive adjustment” provision in the State plan – that it did not require Illinois to reconcile estimated payments to actual costs, but simply enabled Illinois to adjust DSH payments if a hospital appealed for a higher DSH add-on amount and won – is unreasonable in light of the language and organization of the plan as a whole. We next describe why we reject Illinois’ contentions that the Board should reverse the disallowances because Congress and CMS did not require states to recoup estimated DSH payments in excess of actual costs until 2011 and that it has been held to a standard that CMS did not apply to other states. Lastly, we address Illinois’ arguments that the Board should overturn the disallowances on the grounds that they were “untimely and prejudicial.”

2. Illinois did not follow the methodology in its State plan.

The Medicaid state plan amendment process is more than a mere procedural exercise. *Mo. Dep't of Social Servs.*, DAB No. 1229, at 5 (1991). The Act “makes clear that the Secretary has the authority—indeed, the obligation—to ensure that each of the statutory prerequisites is satisfied before approving a Medicaid state plan amendment.” *Alaska Dep't of Health and Social Servs. v. Centers for Medicare & Medicaid Servs.*, 424 F.3d 931, 939 (9th Cir. 2005). It therefore follows that a state “plan must specify

comprehensively the methods and standards” that the state will use to set payment rates for hospital services. 42 C.F.R. § 447.252(b). The state plan must contain “all information necessary for CMS to determine whether the plan can be approved....” 42 C.F.R. § 430.10.

Based on these requirements, the Board has long held that states must follow the processes, standards and methods set out in their approved state plans and may not change their plan methodologies unilaterally. *See, e.g., Colo. Dep’t of Health Care and Policy Fin.*, DAB No. 2057 (2006); *N.H. Dep’t of Health and Human Servs.*, DAB No. 1862 (2003); *Ca. Dep’t of Health Servs.*, DAB No. 1007 (1989). A state “is not excused from complying with the terms of its state plan even if the methodology followed by the state was consistent with its administrative rules and would have been approved by the federal agency if submitted as a state plan.” *Iowa Dep’t of Human Servs.*, DAB No. 1248, at 8 (1991) (citations omitted).

To evaluate whether a state has followed the terms of its approved state plan, the Board looks to the text of the relevant provisions. If the wording is clear, then it will control. If the language is subject to more than one possible interpretation, that is, if it is ambiguous, the Board will defer to the state’s proposed interpretation if it is reasonable in light of the purpose of the provision and program requirements, gives effect to the language of the plan as a whole, and is supported by consistent administrative practice. *S.D. Dep’t of Social Servs.*, DAB No. 934, at 4 (1988); *N.J. Dep’t of Human Res.*, DAB No. 2107, at 6 (2007). While “a state has considerable flexibility in choosing standards, methods and payment rates for each type of service included under its state plan,” it “is ‘not free to implement ad hoc changes or ignore the methodology set out in [its] approved state plan.’” *Utah Dep’t of Health*, DAB No. 2131, at 9 (2007), citing *La. Dep’t of Health and Hosps.*, DAB No. 1542, at 2 (1995), *aff’d*, *La. Dept. of Health & Hosps v. HHS*, No. 95-942-A-MI (M.D. La. Dec. 18, 1997). The state “must use the methodology in the state plan[], once adopted and approved.” DAB No. 1542, at 2.

The process that Illinois used to calculate and apply the hospital-specific DSH limits during the audit period is described in the written declaration of Illinois Senior Public Service Administrator Mark McCurdy. IL Ex. 3. Mr. McCurdy states that, prior to each rate year, Illinois prospectively calculated each hospital’s hospital-specific limit by adding together estimated “Medicaid inpatient costs, Medicaid outpatient costs and uncompensated care costs.” *Id.* ¶ 6. Illinois calculated Medicaid inpatient costs “in the same way that inpatient costs were calculated for the Medicare Upper Payment Limit . . . test,” “based on each hospital’s ‘costs per discharge,’ for a base year of [SFY] 1992 . . . adjusted . . . using inflationary and case-mix factors . . . [and] applied to the estimated number of discharges for each hospital” for the upcoming year. IL Ex. 3, ¶ 6.a. Illinois estimated Medicaid outpatient costs “using amounts from the outpatient Medicare UPL calculation, which was based on Medicaid outpatient charges from [SFY] 1994, subject to further adjustment and factoring.” *Id.* ¶ 6.b. Illinois estimated “uncompensated care

costs” “based on the uncompensated care charges reported by each hospital” on the state-designed OBRA 1993 Data Collection Form in the second preceding year, inflated by the hospital’s cost-to-charge ratio for the third preceding year. *Id.* ¶ 6.c. Illinois then “compared the total estimated Medicaid payments for the coming year to the estimated hospital-specific limit, to ensure that the hospital-specific limit would not be exceeded.” *Id.* ¶ 7. If the projected Medicaid payments exceeded the projected hospital-specific limit, Illinois would reduce the DSH add-on rate “such that the aggregate [Medicaid] payment would come within the limit.” *Id.*

Applying the Board standards for evaluating whether the process that Illinois used to calculate and apply the hospital-specific DSH limits followed the methodology that Illinois adopted and CMS approved, we turn to the text of the State plan and the parties’ interpretations of its language. As set forth above, Illinois’ State plan described the hospital-specific DSH limit as composed of two parts. First, Illinois would compute “a hospital[’]s cost of inpatient and outpatient services furnished to Medicaid patients, less the amount paid to the hospital for inpatient and outpatient services excluding DSH payments made under this State plan.” IL Ex. 2, at 53. The State plan referred to this part of the limit as the “Medicaid shortfall.” *Id.* Second, the plan provided that “[t]he cost of services provided to patients who have no health insurance or source of third-party payment less any payments made by these patients shall be determined and added to the Medicaid shortfall . . .” *Id.* The plan then specified that the combined “result shall be compared to the hospital[’]s estimated DSH payments,” and if the “estimated DSH payments exceed the DSH limit (Medicaid shortfall plus cost of uninsured) then the Department will reduce the hospital[’]s DSH rate per day so that their DSH payments will equal the DSH limit.” *Id.* Finally, the provision stated, “[i]f necessary, retroactive adjustments will be made.” *Id.*

CMS and Illinois present conflicting interpretations of the State plan language, which highlight inconsistencies in the text. Illinois argues that the wording “clearly refers to a prospective comparison of costs to payments.” IL Br. at 16. To support its interpretation, Illinois points to the language in the provision stating that: payments “shall be made”; the adjustment “will be computed”; other costs “shall be added”; the result “shall be compared” to “estimated payments”; and the Department “will reduce” the DSH rate “so that DSH payments will equal the DSH limit.” *Id.* “In context,” Illinois says, “it is clear that the provision is not looking at actual costs and payments but at projections of costs and payments in the payment year.” *Id.* Furthermore, Illinois contends that the retroactive adjustment provision in the last sentence of the provision did not mean that Illinois had to compare the Medicaid payments it made based on estimates with actual costs, and then make retroactive adjustments to ensure the DSH payments did not exceed the limits. Rather, Illinois says, the sentence merely “enabled Illinois to adjust DSH payments if a hospital appealed for a higher DSH [add-on] adjustment” prior to the coming rate year and, after a potentially lengthy period, won the appeal. *Id.*

In contrast, CMS points to wording in the text indicating that the DSH payments made over the course of a rate year were provisional, and that Illinois was required subsequently to reconcile the payments to actual costs. CMS argues that “the reference . . . to the hospital’s ‘cost of inpatient and outpatient services *furnished* to Medicaid patients, less the amount *paid*’ refers to historically fixed data points – *i.e.* amounts that were paid and costs for services furnished.” CMS Br. at 16 (emphasis supplied). “Most strikingly,” CMS contends, “the only reference in the plan provision to ‘estimates’ is with regard to the DSH payments themselves,” which the plan required Illinois to adjust based on actual payments and costs. *Id.* With respect to Illinois’ reliance on future-tense verbs in the provision to support its interpretation, CMS observes that the future tense is used generally throughout the State plan because the plan “governs conduct that has not yet occurred. . . .” *Id.* at 17. CMS also says that the only “plausible explanation for the meaning of the ‘retroactive adjustments’ language” is that “estimated DSH payments are required to be reconciled with actual costs and payments, and retroactively adjusted to ensure that DSH payments do not exceed the applicable limits.” *Id.* at 18-19.

Notwithstanding the ambiguities in the State plan language that are reflected in the parties’ different interpretations, we find that Illinois’ process for calculating each hospital’s DSH limit during the audit period cannot reasonably be considered to have followed the methodology that Illinois established, and CMS approved, in the State plan. Under the Act and Medicaid regulations, it was Illinois’ duty to comprehensively specify in its State plan the methods and standards that it would use to calculate the hospital-specific DSH limits. Act § 1902; 42 C.F.R. §§ 430.10, 447.252, 447.201. No language in the State plan, however, provided for Illinois to compute the hospital-specific DSH limits using the same data and calculations that it used “for the [UPL] test.” IL Ex. 3, ¶ 6.a., b. Following its UPL methodology, Illinois calculated the hospital-specific DSH limits based on estimates of Medicaid inpatient costs that were derived from each hospital’s costs per discharge for a base year of 1992, adjusted for inflation and case-mix factors; and estimates of Medicaid outpatient costs that were derived from Medicaid outpatient charges from SFY 1994. *Id.* Yet, no wording in the State plan’s hospital-specific DSH limit provision indicated that Illinois would calculate the inpatient and outpatient cost components of the limits using inflated and adjusted 1992 or 1994 data.

We note that in defense of the process it followed to calculate and apply the hospital-specific DSH limits during the audit period, Illinois says that its use of “the same methodology for estimating costs that it used for its Medicare upper payment limit calculations” was “an approach that CMS had expressly invited in its 1994 SMDL.” IL Br. at 19, *see also id.* at 4-5 (stating that Illinois’ use of estimates from its inpatient and outpatient UPL calculations was “[c]onsistent with the 1994 SMDL’s reference to the cost principles used in calculating” the UPLs).

Illinois' assertions mischaracterize the 1994 SMDL's instructions. The SMDL stated that in defining "cost of services," for the purposes of the DSH limit calculation (*i.e.* identifying "cost of services to Medicaid patients" and "cost of services to uninsured patients"), a state could "use *the definition of allowable costs in its State plan*, or any other *definition*, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement," which "are the general upper payment limit under institutional payment under the Medicaid program." IL Ex. 1, at 3 (emphasis supplied). Thus, the SMDL did not "invite" states to use the same methodologies to implement section 1923(g) of the Act as they used to calculate the UPLs. Rather, the SMDL's reference to the UPL methodology was for the purpose of ensuring that whatever definition of "cost" a state chose for the purpose of calculating the hospital-specific limits, the use of that definition did not result in amounts that would exceed "a maximum standard that is widely known and used in the determination of hospital costs." *Id.* at 3-4.

Furthermore, Illinois' inclusion of unreimbursed costs of insured patients ("bad debt") in the DSH limits expressly contradicted the plain language of the State plan. That is, the State plan specified that the "cost of uninsured" component of the hospital-specific DSH limit would consist of the "cost of services provided to *patients who have no health insurance* or source of third-party payment less any payments made by these patients[.]" IL Ex. 2, at 53. (emphasis supplied). Illinois instead used "uncompensated care charges" reported by each hospital on the State-designed OBRA 1993 Data Collection Form in the second preceding year, inflated and adjusted by the hospital's cost-to-charge ratio for the third preceding year. IL Ex. 3, ¶ 6.c. As the OIG pointed out, the reported "uncompensated care charges" included uncompensated costs for *insured patients* (unpaid copayments and third-party obligations).⁸ Yet, Illinois made no attempt to back the insured patient costs out of its hospital-specific DSH limit calculations, as required by the plain language of the State plan.

Illinois argues that its inclusion of uncompensated costs of insured patients in its calculation of the DSH limits "should not result in a disallowance because they were specifically permitted" under the State plan's DSH hospital reporting provisions. IL Br. at 19-20. Illinois asserts that the State plan required each hospital to submit information about its "uncompensated care charges," and the State plan definition of uncompensated care charges did not distinguish between insured and uninsured patients. IL Br. at 20, citing IL Ex. 2, at 57, 58.⁹ Regardless of whether the hospital reporting requirements and

⁸ The OIG attributed the inclusion of these amounts to "a lack of clarity" in the OBRA 1993 Data Collection Form, which did not specify that hospitals should report only uninsured patient charges. IL Ex. 7, at 5; IL Ex. 8, at 5.

⁹ The State plan defined "uncompensated care charges" to mean: "the hospital's charges for inpatient, outpatient and hospital-based clinic services for which the hospital was not reimbursed by either the patient or a third party . . . less . . . the amount of the hospital's bad debt recoveries for inpatient, outpatient and hospital-based clinic services . . . provided without charge or at reduced charges under its obligation under the federal Hill-Burton Act[.]" IL Ex. 2, at 58.

OBRA 1993 Data Collection Forms directed hospitals to report “uncompensated care charges,” which did not distinguish between insured and uninsured patients, this would not excuse the State from failing to calculate the DSH limits according to the plain language of the State plan’s hospital-specific DSH limit provision. That provision did not refer to “uncompensated care charges,” but provided that only the unpaid “cost of services provided to *patients who have no health insurance* or source of third-party payment less any payments made by these patients” would be included in the “cost of uninsured” component of the hospital-specific limit. IL Ex. 2, at 53 (emphasis supplied).

Furthermore, we reject Illinois’ argument that its interpretation of the retroactive adjustment provision in the State plan is entitled to deference. Illinois says that the statement, “[i]f necessary, retroactive adjustments will be made,” merely “enabled Illinois to adjust DSH payments if a hospital appealed for a higher DSH adjustment and won.” IL Br. at 16; *see also* IL Reply at 2. Illinois states that, prior to each rate year, a hospital that disagreed with the State’s determination of its DSH add-on amount for the coming rate year could appeal for a higher amount. *Id.* “An appeal could take several months,” however, “during which time the hospital would be receiving DSH payments as part of its inpatient rate.” IL Br. at 16. If the appeal was resolved in the hospital’s favor, Illinois says, it “would again compare estimated payments (with the higher add-on) to the hospital-specific limit and, if necessary would reduce the add-on to stay within the cap, including add-ons that had already been paid.” *Id.* Illinois asserts that it “never interpreted the State plan provision to mean that after it had finalized the payments under its prospective comparison, it was required to use actual cost information and make after-the-fact reconciliations to actual costs.” *Id.* at 16-17. “At best,” Illinois says, the sentence referring to ‘retroactive adjustments’ is ambiguous as to whether the hospital-specific limits should be reconciled to costs, and thus the Board should defer to the State’s longstanding interpretation that the State plan did not require reconciling to actual costs.” IL Reply at 8.

While deference to a state’s interpretation is appropriate where state plan language is ambiguous and the state’s construction is reasonable and supported by the language of the plan as a whole, here Illinois’ proposed interpretation of the State plan’s retroactive adjustment provision is not reasonable in light of the wording of the hospital-specific DSH limit provision and Illinois’ State plan as a whole. This fact is most apparent because no mention of the hospital appeal process appears in the text of the hospital-specific DSH limit provision. Indeed, the criteria for calculating each hospital’s DSH add-on amount were set out in a different section of the State plan, IL Ex. 2, at 46-52, and the appeal process for a hospital to request review of its DSH add-on amount appears to have been established and described in an entirely different chapter of the State plan. IL Ex. 2, at 52 (indicating that appeals of payment adjustment amounts are set out in Chapter IX). This division between the hospital-specific DSH limit methodology and the process for a hospital to appeal its add-on amount was also reflected in the Illinois

Administrative Code, which addressed the hospital-specific DSH limits and the process for a hospital to request review of its DSH add-on amount in two separate sections. CMS Ex. 1, at 11 (89 Ill. Admin. Code § 148.120(j)(4) (1995)); CMS Ex. 5, at 2 (89 Ill. Admin. Code § 148.310(b) (1995)).

Moreover, the statement that Illinois would make “retroactive adjustments” used the broad term, “[i]f necessary,” and referred to the computation described in the immediately-preceding sentences. Those sentences required Illinois to compare a hospital’s DSH limit to estimated DSH payments and to reduce the hospital’s DSH rate in the event that “the estimated DSH payments exceed the DSH limit. . . .” IL Ex. 2, at 53. Since the description of the comparison used the term “estimated” only with respect to the DSH payments, and not with respect to the DSH limit (or its component costs), the OIG and CMS naturally read the retroactive adjustment provision to require reconciliation of estimated payments to actual costs composing the DSH limit. In light of the wording of the “retroactive adjustments” provision, the language to which it refers, and the absence of any mention in the provision to the hospital appeal process, Illinois’ proposed interpretation cannot be considered reasonable. Conversely, OIG and CMS logically inferred from the text that the hospital-specific DSH limit methodology required Illinois to reconcile the estimated DSH payments to a hospital’s actual Medicaid shortfall and “cost of insured” and to make retroactive adjustments if necessary to ensure that DSH payments to a hospital did not exceed the hospital’s applicable limit.

In sum, Illinois was responsible for providing in its proposed State plan amendment sufficient detail of the “the methods and standards” that it would use to calculate the hospital-specific DSH limits for CMS to ensure that the plan complied with the Act and regulations. 42 C.F.R. §§ 430.10, 447.252, 447.201. Illinois did not specify or even suggest in its proposed amendment that it would use data and computations drawn from its UPL methodology – including the use of 1992 inpatient cost data and 1994 outpatient charge data – to calculate the hospital-specific DSH limits. Illinois also did not reveal that it would include in its determination of the “cost of uninsured” unpaid copayments and deductibles of insured patients. Nor did Illinois use language limiting the applicability of the “retroactive adjustments” provision to situations involving hospital appeals or otherwise indicate why the provision should not have been read as anything other than a requirement that Illinois reconcile estimated DSH payments to actual costs.

3. CMS statements made in response to a 2006 OIG draft report and in the preamble to a 2008 rulemaking do not bar the disallowances.

Illinois argues that requiring it to “reconcile hospitals’ estimated uncompensated costs with their actual costs, and to recoup any putative excess” imposes on Illinois a standard that did not exist during the audit period, “as CMS implicitly acknowledged in its response to the OIG in 2006, and expressly acknowledged in a public rulemaking in 2008.” IL Br. at 9. Illinois refers to a 2006 statement made by CMS in response to an OIG draft audit report and to the CMS final rule implementing section 1923(j) of the Act, which established new reporting and audit requirements for state DSH payments. IL Ex.

9, *Audit of Selected States' Medicaid Disproportionate Share Hospital Programs*, March 2006 (2006 OIG Audit Report); 73 Fed. Reg. 77,904, 77,951 (Dec. 19, 2008) (“Final DSH Audit Rule”). According to Illinois, CMS is “holding Illinois to a standard in 1997 that CMS did not apply to other States until more than a decade later.” IL Br. at 9.

The 2006 OIG audit report referenced by Illinois consolidated findings relating to 10 states, including Illinois. The OIG determined that nine of the states did not comply with the hospital-specific DSH limits established in section 1923(g) of the Act. In its draft of the report, the OIG recommended that CMS “ensure that the monetary recommendations concerning DSH payments that exceeded the hospital-specific limits have been resolved[.]” IL Ex. 9, 2006 OIG Audit Report at 8. CMS’s Administrator at the time provided comments to the draft report, stating in part that CMS “interpret[ed] this recommendation as a prospective resolution and not a requirement to recoup any Federal payments associated with these findings.” *Id.* App. B at 2. Illinois characterizes the CMS Administrator’s comment as making “clear that CMS would not be taking disallowances based on the OIG’s findings with respect to the calculation of hospital-specific limits.” IL Br. at 7 (emphasis by Illinois).

We disagree with Illinois’ characterization. The CMS Administrator’s statement, read in context as a comment to a draft report, does not constitute a determination by CMS that it would not issue disallowances of state claims for FFP in DSH payments exceeding actual costs for prior periods. We further note that the comment continued, “the affected States did not always have reconciliation in their State plan” IL Ex. 9, App. B at 2. Thus, even if a state interpreted the comment to indicate that CMS did not at the time intend to issue disallowances for prior periods, the rationale underlying that position would not apply where, as in Illinois’ case, a state plan *did* require reconciliation. Moreover, the disallowances here do not hold Illinois to a standard to which other states have not been held. As reflected in the Board’s decision in *Louisiana*, DAB No. 2350, where a state plan implemented the hospital-specific DSH limits by requiring estimated DSH payments to be reconciled to actual uncompensated costs, the Board concluded that FFP is allowable only in DSH payments determined according to that methodology.

Illinois also states that the 2008 Final DSH Audit Rule for “the first time ever . . . articulated a federal-law requirement that States reconcile estimated and actual [uncompensated care costs].” IL Br. at 13-14, citing 73 Fed. Reg. at 77,951, *codified at* 42 C.F.R. § 455.304(d)(2). Illinois says that the Final DSH Audit Rule did not require DSH payments in excess of audit-determined actual uncompensated costs to be deemed overpayments until state plan rate year 2011. IL Br. at 9. Illinois relies on the following preamble language to support its argument:

Beginning in Medicaid State plan rate year 2011, to the extent that audit findings demonstrate that DSH payments exceed the documented hospital-specific cost limits, CMS will regard them as representing discovery of overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, triggers the return of the Federal share to the Federal government

[W]ith respect to requiring recovery of any overpayments, the regulation does not impose an immediate penalty that would result in the loss of Federal matching dollars. . . . [B]ecause a trial period will be required for auditors to refine audit methodologies, findings from Medicaid State plan rate years 2005 through 2010 will be used only for the purpose of determining prospective hospital-specific cost limits and the actual DSH payments associated with a particular year.

73 Fed. Reg. at 77,906 (emphasis added). Illinois argues that in the preamble, CMS “recognized the need for a ‘trial period’ for the refinement of audit methodologies, and it reiterated that audit findings for periods before state plan rate year 2011 were to be used only prospectively, not for retroactive disallowances.” IL Br. at 14. Illinois says that the “Final DSH Audit Rule confirms that federal law did not require reconciliation and recoupment during the period” at issue here and that the “strictly *prospective* nature of the regulation leaves no doubt that federal law, at least during the disallowance period, *never* mandated the approach that CMS now purports to require.” *Id.* at 15 (emphasis by Illinois).

The Board decision in *Louisiana*, DAB No. 2350, addressed and rejected similar arguments. As the Board explained in that decision, federal law has always required states to reimburse hospitals according to the methodologies in their approved Medicaid state plans, and, with limited exceptions, required a state to return the federal share of any payments to hospitals in excess of the amounts determined according to the state plan. DAB No. 2350, at 17. “A careful reading of the preamble to the Final DSH Audit Rule,” the Board further explained, evidences that the transition period provided with respect to the “independent certified audit” requirements imposed on states under section 1923(j) of the Act, was “not intended to preclude review of DSH payments and discovery of overpayments” by means other than the independent certified audits pursuant to the new requirements. *Id.* Thus, the transition period provided under the Final DSH Audit Rule did not bar the disallowances here, which are based on the language of Illinois’ own State plan and longstanding statutory and regulatory requirements.

Illinois further argues that CMS recognized in the preamble to the 2008 rule that some hospitals at the time did not separately identify uncompensated costs related to services provided to individuals with no source of third party coverage from “bad debt,” which “arises when there is non-payment on behalf of an individual who has third party coverage.” *Id.* at 21-22, quoting 73 Fed. Reg. at 77,909, 77,911. Significantly, Illinois states, CMS “emphasized that hospitals would be given ample time to bring their systems into compliance with the new definition” of uncompensated care costs. IL Br. at 22. Illinois asserts that imposing disallowances against Illinois because “the hospitals included some bad debt in their uncompensated cost calculations” holds “Illinois to a

different standard than that which [CMS] promised in the 2008 Final DSH Audit Rule” and is “particularly inequitable given that CMS had approved Illinois’ plan language [*i.e.*, definition of uncompensated care charges] that excluded only bad debt that had been recovered.” *Id.* at 23.

We reject this argument. While CMS recognized in the Final DSH Audit Rule that some hospitals needed “to modify their accounting systems to separate the two categories in order to properly document that DSH payments are within the hospital-specific limit,” the language of the statute, CMS stated, was unequivocal: “Section 1923(g)(1) is clear that the hospital-specific uncompensated care limit is calculated based only on costs arising from individuals who are Medicaid eligible or uninsured, not costs arising from individuals who have third-party coverage.” 73 Fed. Reg. at 77,910. Thus, the plain language of the Act put states on notice that bad debt should not be included in the hospital-specific uncompensated care DSH limit. In any event, the disallowances here are supported by the language of the hospital-specific DSH limit methodology in Illinois’ state plan, which explicitly imposed on the State the obligation to ensure that only the “cost of services provided to *patients who have no health insurance or source of third-party payment*” and the “Medicaid shortfall” be included in the hospital-specific DSH limit. IL Ex. 2, at 53 (emphasis added).

4. *Illinois’ claim for equitable relief is not a proper basis for reversal.*

Lastly, Illinois argues that CMS’s decision to issue the disallowances “nearly twelve years after the OIG’s 2004 disallowance recommendation and a full 20 years after the start of the audit period” is inequitable and prejudicial. IL Br. at 7. “To the extent that the Board disagrees” with Illinois “and finds that federal law or the state plan required reconciliation and recoupment during the disallowance period,” Illinois states, the “disallowance should be overturned as untimely and prejudicial.” IL Br. at 10 n.4. As detailed in the foregoing analysis, CMS properly took disallowances in this case based on longstanding provisions in the Act and regulations and the language of Illinois’ State plan. The Act and regulations “contain no statute of limitations or other time limit on the issuance of Medicaid disallowances.” *Ca. Dep’t of Health Care Servs.*, DAB No. 2204, at 9 (2008). Furthermore, the Board’s regulations make clear that we must uphold a disallowance if it is supported by the evidence and is consistent with the applicable statutes and regulations. 45 C.F.R. §§ 16.14, 16.21. Thus, even the extensive delay in issuing the disallowances has no legal significance. Accordingly, we sustain the disallowances.

Conclusion

For the reasons stated above, we sustain the disallowances.

_____/s/
Susan S. Yim

_____/s/
Constance B. Tobias

_____/s/
Leslie A. Sussan
Presiding Board Member