IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services, Defendant.	Case No. _____

COMPLAINT

Introduction

1. Plaintiff, the Illinois Department of Healthcare and Family Services ("HFS," "Illinois," or the "State"), brings this action under the Administrative Procedure Act, 5 U.S.C. §§ 701, *et seq.*, to challenge a final decision by the Departmental Appeals Board (the "Board") of the United States Department of Health and Human Services ("HHS") affirming a 2016 decision by HHS's Centers for Medicare and Medicaid Services ("CMS") that disallowed, and required repayment of, more than $140 million in federal reimbursements for Medicaid payments by HFS to two Illinois "safety-net" hospitals from July 1, 1996 through June 30, 2000. Copies of the Board's original decision and its order denying Illinois' motion for reconsideration (collectively, the "Decision") are attached as Exhibits 1 and 2.

2. The Decision is arbitrary and capricious, an abuse of discretion, and contrary to law.

3. The parties' dispute relates to the meaning of the provision in Illinois' "State Plan" governing limits on Medicaid payments to "disproportionate share hospitals." Such payments — commonly referred to as "DSH payments" — are authorized by section 1902(a)(13) of the Social Security Act, 42 U.S.C. § 1396a, and constitute additional Medicaid payments to hospitals that serve high numbers of poor and uninsured patients.

4. In 1993, Congress added subsection (g) to section 1923 of the Social Security Act (42 U.S.C. § 1396r–4). Pub. L. No. 103-66, 107 Stat. 312 (1993). Section 1923(g) limits the DSH payments that an individual hospital may receive to an amount equal to the difference, or shortfall, between the hospital's costs for providing services to Medicaid and uninsured patients, and the payments it receives from, or for, those patients. Following enactment of section 1923(g), HFS modified Illinois' State Plan to implement that limit.

5. The central issue in the case concerns CMS's disagreement with Illinois about whether, for the years in dispute, Illinois was allowed to apply a "prospective" method for calculating and applying the DSH payment limit, as Illinois maintains, or was instead required to apply a "retrospective" method for calculating and applying that limit, as CMS maintains.

6. The Board's Decision did not conclude that section 1923(g) required Illinois to apply a retrospective method to calculate the DSH limit. (Ex. 1 at 8.) Instead, the Board's decision concluded that Illinois' State Plan required Illinois to use a retrospective method to calculate that limit. (*Id*. at 14.)

7. The Board's Decision acknowledged that if disputed language in a State Plan "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." (Ex. 1 at 9.) The Board concluded, however, that "Illinois' interpretation of [its] State plan language . . . is unreasonable and not entitled to deference." (*Id*. at 1.) That conclusion is wrong. The relevant language of Illinois' State Plan is, at the very least, reasonably consistent with Illinois' use of a prospective method for calculating the DSH limit. That method gives effect to the State Plan as a whole. And that method conforms to HFS's consistent administrative practice.

8. There are two primary ways for States to calculate and make Medicaid payments to eligible providers, including hospitals: a "prospective" method, and a "retrospective" method. Under the prospective method, a State pays for compensable services during the relevant period using rates based on information from an earlier period. Under the retrospective method, the State typically makes interim payments for compensable services, but then "settles up" — or reconciles — the final payment amount after reviewing the provider's actual costs during the relevant period. The primary difference is that a retrospective method uses the same period to determine costs and payments for covered services, requiring a reconciliation of those costs and payments after that period is over, while a prospective method relies on costs from an

earlier period to set compensation rates for the service period, and therefore does not require such a reconciliation.

9. Illinois, like many other States, historically used a prospective method to calculate and make payments to Medicaid providers, including hospitals. Before Congress enacted section 1923(g) in 1993, Illinois used a prospective method to calculate Medicaid payments generally, as well as DSH payments to hospitals. These payments were based on "rates" for particular services to Medicaid patients. DSH payments took the form of an "add-on" to these basic Medicaid rates. After enactment of section 1923(g), Illinois continued to use a prospective method to determine those payments. Illinois also used a prospective method to calculate the new DSH limit established by section 1923(g). If a hospital's DSH limit was triggered, Illinois reduced the hospital's applicable payment rate.

10. Consistent with Illinois' practice, the provision of its State Plan regarding DSH-limit adjustments for the years in question first required HFS to calculate the hospital's uncompensated costs for inpatient and outpatient services for Medicaid and uninsured patients. This Plan provision then stated:

> The result [of this calculation] shall be compared to the hospitals estimated DSH payments. If the estimated DSH payments exceed the DSH limit (Medicaid shortfall plus cost of uninsured) then the Department [HFS] will reduce the hospitals DSH rate per day so that their DSH payments will equal the DSH limit. If necessary, retroactive adjustments will be made.

11. Contrary to the Board's conclusion in its Decision, this language is reasonably read — and is most reasonably read — to be consistent with HFS's use of

a prospective method to apply the DSH limit. That interpretation is also consistent with: (a) Illinois' State Plan as a whole; (b) HFS's consistent administrative practice; and (c) the similar practice of other States.

12. Among other things, the language in Illinois' State Plan does not reasonably support the Board's interpretation. The language stating that HFS "will reduce the hospitals [sic] DSH rate per day so that their DSH payments will equal the DSH limit" is consistent with HFS's application of the DSH limit using a prospective method. Its specified DSH-limit adjustment could not operate under a retrospective method, which requires that adjustments be made only after the end of the relevant service year, based on final data from that year. The next sentence (the last in the paragraph), stating that retroactive adjustments will be made "[i]f necessary," does not negate that meaning of the preceding sentence. Nor can it reasonably be read to do so, which would deprive that preceding sentence of any effect. Instead, the last sentence anticipates that on some occasions under a prospective method, DSH-limit adjustments may have to be applied "retroactively" — after DSH payment rates and a DSH limit for a year have been established — if circumstances requiring such an adjustment (*e.g.*, if a hospital successfully appeals the calculation of its prospective DSH rate) occur, or are discovered, after HFS has begun to apply them. HFS consistently applied that intended meaning of this provision.

Jurisdiction and Venue

13. This action arises under section 1116 of the Social Security Act, 42 U.S.C. § 1316(e)(2)(C), and the Administrative Procedure Act, 5 U.S.C. §§ 701, *et seq*.

14. This Court has jurisdiction pursuant to 28 U.S.C. §1331 and 1361, which provide for original jurisdiction in suits involving questions arising under federal law and suits to compel action by federal agencies.

15. Judicial review is authorized by the Administrative Procedure Act, 5 U.S.C. § 701, *et seq*. HHS's decision with respect to the disallowance constitutes a "final agency action" within the meaning of 5 U.S.C. § 704.

16. Venue is proper under 28 U.S.C. § 1391(e)(1) and section 1116(e)(2)(C) of the Social Security Act, 42 U.S.C. §1316(e)(2)(C).

Parties

17. In Illinois, HFS is the "single State agency" responsible for administration of the State of Illinois' participation in the federal Medicaid program. *See* 42 U.S.C. § 1396a(a)(5).

18. Defendant Alex M. Azar II is named in his official capacity as HHS Secretary, with overall responsibility for the administration of the agency. HHS is the federal agency responsible for administering the Medicaid program, which it administers through CMS.

The Medicaid Program and Medicaid Funding

19. Medicaid is a cooperative federal–state program under which the federal government provides financial assistance to participating States in connection with the provision of health care to lower-income individuals and families.

20. Under the Medicaid statute (Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq.*), States are entitled to reimbursement for a specified percentage of the actual costs they incur in providing health care to their Medicaid-eligible populations. *Id.* § 1396b(a).

21. A State participating in the Medicaid program must obtain CMS's approval of its state plan for medical assistance. *Id.* § 1396a. The State receives federal reimbursement for its expenditures on medical assistance under its state plan. *Id.* § 1396b.

22. The federal government's share of a State's expenditures under the Medicaid program is called "federal financial participation" (or "FFP"). 42 C.F.R. § 400.203; 45 C.F.R. § 95.4. For Illinois, the federal financial participation for its Medicaid program is about half of the total paid by HFS.

Medicaid DSH Payments, Allotments, and Limits

23. Section 1902(a)(13)(A)(iv) of the Social Security Act, 42 U.S.C. § 1396a(a)(13)(A)(iv), requires state Medicaid programs to make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. The purpose of the DSH provision is to ensure the continued viability of hospitals serving a disproportionate share of low-income patients by providing these hospitals

with additional funds, beyond the payments those hospitals receive for delivering specific services to Medicaid enrollees.

24. DSH payments, which are added to basic Medicaid payment rates, are only available to hospitals that serve low-income and Medicaid patients above a statutorily set threshold. 42 U.S.C. § 1396r–4(b), (d). States have discretion in determining what hospitals qualify for DSH payments, as well as the DSH rates that apply to them.

25. The DSH payments at issue in the case were made to two "safety-net" hospitals in Chicago: Mt. Sinai Hospital, and the hospital at the University of Illinois in Chicago ("UIC Hospital"). Safety-net hospitals provide healthcare for individuals regardless of their insurance status or ability to pay. Mt. Sinai Hospital is located in the North Lawndale neighborhood of Chicago. UIC Hospital is a major teaching institution located on Chicago's near west side. Both Mt. Sinai Hospital and UIC Hospital provide healthcare to a high percentage of low-income and uninsured individuals.

26. In 1991, Congress added subsection (f) to section 1923 of the Social Security Act, 42 U.S.C. § 1396r-4(f)(3), to establish an annual "DSH allotment" for each State that places a dollar limit on the federal financial participation for its total statewide DSH payments to hospitals.

27. In 1993, section 1923(g) of the Social Security Act established an additional limit — often called the "hospital-specific DSH limit," or "DSH limit" — on the DSH payments that an individual hospital may receive. Under the hospital-

specific DSH limit, the DSH payments that a hospital may receive in a year cannot exceed its unreimbursed costs incurred in providing services to Medicaid and uninsured patients (*i.e.*, its costs for providing those services minus the payments it receives for, or from, those patients).

Types of Reimbursement Methodologies

28. States have significant flexibility in setting their Medicaid reimbursement rates for hospitals and other providers. While some States pay on a retrospective basis, in which final payments are adjusted based on a hospital's costs of providing services, others pay prospectively, setting a rate in advance. This is how the HHS' own Departmental Appeals Board describes the two systems:

> In a "retrospective" system, a state makes payments to a provider such as a hospital during a rate period (usually a fiscal or calendar year) based on an "interim" rate. The interim rate is based on an estimate of the costs of providing services (usually historical costs adjusted for expected inflation). At the end of the rate period, the provider submits a cost report of the actual costs incurred during that period. The cost report is subject to review and audit (and potentially a provider appeal). During this cost settlement process, interim payments are reconciled to actual costs and final payment is made. In contrast, payments made as part of a "prospective" reimbursement system are not adjusted based on actual costs incurred during the period in which the services were provided.

Louisiana Dept. of Health and Hospitals, DAB No. 2350 (2010) (emphasis added).

29. Prospective payment systems are widely used for publicly supported medical services, including Medicaid and Medicare. Among other things, prospective payment systems encourage efficiencies in providing covered services.

30. For the period in dispute, many States, including Illinois, calculated DSH limits using a prospective method. CMS later admitted that many of these States considered its guidance on whether that method was proper to be inadequate.

Illinois' Fiscal Year 1997 through 2000 DSH Payments

31. For the disputed period, Illinois used a prospective methodology to implement the hospital-specific DSH payment limit. This prospective methodology consisted of a three-step process: *First*, HFS, using data including historic and projected utilization rates, projected each hospital's Medicaid payments and DSH add-on payments for the upcoming year. *Second*, based on data from prior years, HFS estimated each eligible hospital's anticipated Medicaid inpatient costs, Medicaid outpatient costs, and uncompensated care costs, and added them together to determine its hospital-specific DSH limit for the year. *Third*, HFS compared each DSH-eligible hospital's projected Medicaid payments for the coming year to its hospital-specific limit, to ensure that the hospital-specific limit would not be exceeded. If HFS determined that the estimated hospital-specific limit for a hospital would be exceeded, HFS would reduce its DSH add-on rate so that the aggregate payment to it would come within the limit.

32. HFS informed hospitals of their payment rates, including the DSH add-on, by annual letter. Hospitals could appeal the payment rates if they believed any aspect was incorrect. Under HFS's prospective method, such an appeal could require a change in the hospital's DSH limit and corresponding DSH add-on even after HFS

began applying the DSH add-on, subject to the DSH limit, that HFS had originally calculated for that year.

33. The hospital-specific DSH limits did not automatically reduce, dollar-for-dollar, the federal funding that Illinois received for DSH payments to Illinois hospitals. Under section 1923(f), Illinois, like other States, received a finite amount of money from the federal government for its state-specific DSH allotment that was always significantly less than the total amount of DSH payment its DSH-eligible hospitals otherwise could have received after applying their hospital-specific DSH limits. 42 U.S.C. § 1396r-4(f). Consequently, as the CMS Administrator recognized, requiring a State that had used a prospective method to calculate DSH limits to change that method for past years and calculate those limits using a retrospective method did not mandate a refund of federal payments for those years because, among other things, "States always have the ability to redistribute DSH payments within their DSH allotments." That is true for Illinois' use of a prospective methodology to calculate DSH limits, which affected the distribution of its DSH allotment among DSH-eligible hospitals, but, even under a retrospective method for the years in dispute, did not reduce the total DSH payments available to the State.

CMS's 2004 Audits and 2006 Decision to Reject Retroactive Disallowance

34. During state fiscal years 1997 through 2000, Illinois made approximately $338 million in DSH payments to UIC Hospital, and approximately $39.3 million in DSH payments to Mt. Sinai Hospital.

35. In 2004, the CMS Office of Inspector General ("OIG") completed audits of Illinois' DSH payments to UIC Hospital and Mt. Sinai Hospital for state fiscal years 1997 through 2000. In these reports, OIG recommended that CMS disallow $140,281,921 in federal financial participation for Illinois' DSH payments to UIC Hospital, and another $4,516,112 in federal financial participation for Illinois' DSH payments to Mt. Sinai Hospital.

36. The OIG recommended these disallowances based on its conclusion that section 1923(g) and Illinois' State Plan each required Illinois to use a retrospective method for applying the DSH limit instead of the prospective method Illinois used. The OIG's reports stated, among other things, that Illinois "did not compare Medicaid payments (including DSH payments) with actual Medicaid and charity care costs," and it "did not adjust DSH payments as required by the State plan's retroactive adjustment provisions."

37. The OIG also asserted that Illinois had improperly included "bad debt" in its calculation of the uncompensated care costs that served as the basis for each hospital's hospital-specific DSH limit. The OIG later stated that this amounted to $972,810 (or less than 0.68%) of its $144,798,033 disallowance recommendation. CMS ultimately disallowed this $927,810, and Illinois does not challenge that particular part of these disallowances in this action.

38. In 2006, the OIG drafted a summary report regarding these and similar audits the OIG had conducted for other States that, like Illinois, had used a prospective method to calculate DSH limits. Based on the OIG's interpretation of

section 1923(g), its 2006 report recommended that CMS disallow payment for DSH payments covered by these audits, including Illinois' DSH payments at issue in this matter. In response to this recommendation, then-CMS Administrator Dr. Mark McClellan explicitly stated that CMS would not be taking disallowances based on the OIG's findings with respect to the calculation of the hospital-specific DSH limits. Administrator McClellan stated:

> We interpret this recommendation as a prospective resolution and not a requirement to recoup any Federal payments associated with these findings. As the OIG report points out, the affected States did not always have reconciliation in their State plan and/or required the return of the DSH payment upon receipt of such payment. Moreover, many of the affected States contend CMS guidance was inadequate. In addition, States always have the ability to redistribute DSH payments within their DSH allotments.

39. Pursuant to a CMS regulation that took effect in 2009, States were required to submit annual audits of their DSH payments. 42 C.F.R. § 455.304. This regulation included a transition period under which audits for state plan years 2005 through 2010 would be used to assess the reasonableness of uncompensated care cost estimates used for calculations of prospective DSH payments only "for Medicaid State plan year 2011 and thereafter." 42 C.F.R. § 455.304(e). CMS's related guidance made clear that "audit findings from Medicaid State plan rate year 2005–2010 will be limited to use for the purpose of estimating prospective hospital-specific uncompensated care cost limits in order to make actual DSH payments in the upcoming Medicaid State plan rate years," and that "CMS is not requiring

retroactive collection for Medicaid State plan rate years that have already passed." 73 Fed. Reg. 77946.

CMS's 2016 Disallowances

40. On July 25, 2016, nearly 12 years after the OIG's 2004 disallowance recommendation, and 20 years after the start of the audit period, CMS issued disallowances of $140,281,921 (for UIC Hospital) and $4,516,112 (for Mt. Sinai Hospital). CMS did not explain why it had decided at this time, despite CMS Administrator McClellan's contrary decision 10 years earlier, to seek these disallowances.

41. Illinois requested reconsideration of the disallowances. CMS denied both requests.

The Departmental Appeals Board's Decision

42. Illinois timely appealed CMS's disallowance decisions to the Board, which consolidated the two appeals.

43. In the consolidated appeal, the Board upheld CMS's disallowance on April 2, 2018.

44. The Board did not conclude that Illinois' calculation of the hospital-specific DSH limits violated section 1923(g) of the Social Security Act. Instead, the Board held only that that Illinois' DSH payments during the audit period to the two hospitals (UIC and Mt. Sinai) were inconsistent with its State Plan. (Ex. 1 at 14.)

45. The Board acknowledged that it should defer to Illinois' reasonable interpretation of ambiguous provisions its State Plan:

> If the wording [of a State Plan] 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.

(Ex. 1 at 9.) The Board concluded, however, that Illinois' interpretation of its State Plan as providing for a prospective calculation of the hospital-specific DSH limits was "unreasonable and not entitled to deference." The Board further held 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." (*Id*. at 8.)

46. The Board also rejected Illinois' argument "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' was inequitable and prejudicial." (Ex. 1 at 17.) The Board recognized there was an "extensive delay" in CMS's declaring the disallowances, but it concluded that because there is no statute of limitations on Medicaid disallowances, the delay "has no legal significance." (*Id*.)

47. Illinois timely sought reconsideration of the Board's decision. Illinois maintained that the Board's reading of the language in Illinois' State Plan — which in effect converted Illinois' method for applying DSH limits from a prospective one to

a retrospective one — was inconsistent with the text and intended meaning of the document, and contrary to Illinois' longstanding administrative practice.

48. With its motion, Illinois submitted additional documents that totaled less than 75 pages. Among those documents, for example, were recently uncovered letters between Illinois and defendant HHS dating back as far as 1995 that provide contemporaneous evidence that CMS was aware of and accepted Illinois' prospective DSH payment and calculation methods.

49. On January 27, 2019, the Board sustained its original decision, determining that Illinois had not identified a clear error of law or fact in the Board's initial decision. The Board also refused to consider the recently discovered documents provided by Illinois, stating that it "is not the type of newly discovered or previously unavailable documentation that might justify reconsideration of a final decision." (Ex. 2 at 1.)

50. After the Board issued its Decision, CMS began administratively recovering the disputed DSH payments in the amount of more than $20 million per quarter, plus interest, by offsetting that amount against HHS's federal financial participation in Illinois's ongoing Medicaid payments.

51. The Board's decision affirming CMS's disallowance of DSH's payments to UIC Hospital and Mt. Sinai Hospital for the period at issue on the ground that they were contrary to Illinois' State Plan was arbitrary and capricious, an abuse of discretion, and contrary to law.

52. The Board's decision rejecting Illinois' position that CMS's disallowance of more than $140 million in payments was inequitable and prejudicial was arbitrary and capricious, an abuse of discretion, and contrary to law in light of, among other things: (a) the long lapse of time before CMS's disallowance of the DSH payments in dispute; (b) CMS's statements in 2006 and 2009 that it would not retroactively disallow or seek recovery of federal Medicaid contributions corresponding to DSH payments previously calculated based on a prospective method; (c) the fact that Illinois' available DSH payments would not have been lower if it had used a retrospective method to calculate DSH limits during the disputed period; and (d) the practical difficulty, or impossibility, for Illinois now to reallocate its DSH allotment for that period to transfer DSH payments from UIC Hospital and Mt. Sinai Hospital to other DSH-eligible hospitals.

53. The Board's decision to reject consideration of the additional evidence provided by Illinois with its Motion for Reconsideration was arbitrary and capricious, an abuse of discretion, and contrary to law.

WHEREFORE, Illinois requests that this Court grant the following relief:

A. Reverse the Board's Decision.

B. Permanently enjoin Defendant and his agents, employees, successors in office, and all persons acting in concert or participation with him, from disallowing the Medicaid reimbursements at issue or seeking recovery of those reimbursements.

C. Order and instruct Defendant and his agents, employees, and successors in office to return any of the Medicaid reimbursements at issue that have already been disallowed and recovered;

D. Award Plaintiff HFS such additional injunctive, declaratory, and other relief as may be just and proper;

E. Award Plaintiff HFS the costs of this action, including attorneys' fees, to the extent allowed by law; and

F. Retain jurisdiction over this action for such additional and supplemental relief as may be required to enforce the Court's order and judgment.

March 18, 2019

ILLINOIS DEPARTMENT OF
HEALTHCARE AND FAMILY SERVICES,

By: KWAME RAOUL,
Illinois Attorney General

/s/ Richard S. Huszagh
Assistant Attorney General

R. Douglas Rees
C. Hunter Wiggins
David F. Buysse
Office of the Illinois Attorney General
100 West Randolph Street, 12th Floor
Chicago, Illinois 60601
Tel. 312-814-2587
rhuszagh@atg.state.il.us
drees@atg.state.il.us
cwiggins@atg.state.il.us
dbuysse@atg.state.il.us

Exhibit 1

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.

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[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 plan[4]

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 hospitals 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 hospitals 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

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[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

Exhibit 2

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Illinois Department of Healthcare and Family Services
Request for Reconsideration of Decision No. 2863
Ruling No. 2019-1
January 17, 2019

RULING ON REQUEST FOR RECONSIDERATION

The Illinois Department of Healthcare and Family Services (Illinois) asks the Board to reconsider the decision in *Illinois Department of Healthcare and Family Services*, DAB No. 2863 (2018). The decision upheld the Centers for Medicare & Medicaid Services' (CMS's) disallowances of federal financial participation (FFP) in Medicaid disproportionate share hospital (DSH) payments to two hospitals for state fiscal years 1997 through 2000 on the ground that Illinois did not comply with its Medicaid State plan methodology for calculating and applying the DSH hospital-specific payment limits.

In its Motion for Reconsideration (Motion), Illinois argues that the Board erred in rejecting the State's interpretation of its Medicaid State plan because the Board did not read the State plan comprehensively or consider Illinois' intent and consistent administrative practice, as the Board's standards for construing state plan language require. Illinois also alleges that the Board made an error of fact in analyzing the State plan. Illinois submitted additional evidence to support its Motion.

For the reasons discussed below, we conclude that Illinois has not identified a clear error of law or fact in the Board's decision. We also conclude that the additional evidence proffered by Illinois is not the type of newly discovered or previously unavailable documentation that might justify reconsideration of a final decision. Accordingly, we deny Illinois' Motion.

Standard of Review

The Board may reconsider its own decision "where a party promptly alleges a clear error of fact or law." 45 C.F.R. § 16.13. In a case involving a Medicaid disallowance, a party has 60 days from the date of the Board's decision to request reconsideration. Social

Security Act (Act)[1] § 1116(e)(2)(B). The Board will not reconsider a decision "to address an issue that could have been raised before, but was not, or to receive additional evidence that could have been presented to the Board before it issued its decision, but was not." *Ruling on Request for Partial Reconsideration of DAB No. 2103, Alaska Dep't of Health and Soc. Servs.*, Ruling No. 2008-1, at 4 (2007).[2] The Board's "standard is similar to the one applied under Federal Rule of Civil Procedure 59(e), which authorizes a motion to alter or amend a judgment." *Id.* n.*. Rule 59(e) motions generally "are granted only to correct manifest errors of law or fact or to consider newly discovered or previously unavailable evidence." *Id.* (citing *Wright, Miller & Kane*, 11 Federal Practice and Procedure 2d § 2810.1).[3]

Background and Illinois' Motion

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) amended section 1923 of the Act by requiring states to impose hospital-specific caps on Medicaid DSH payments. Pub. L. No. 103-66, § 13621, 107 Stat. 312, 629-33 (1993). To implement the statute, Illinois submitted, and CMS approved, a state plan amendment (SPA) that read:

> Omnibus Budget Reconciliation Act of 1993 (OBRA '93) Adjustments. 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

[1] The current version of the Social Security Act is available at https://www.ssa.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.

[2] Available at https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2007/Ruldab2008-1.pdf.

[3] Although the Federal Rules of Civil Procedure are not controlling in the Board's review process, the Board has looked to the Rules and related cases for guidance. *E.g., Chateau Nursing & Rehab. Ctr.*, DAB No. 2427, at 8 (2011).

> patients shall be determined and added to the Medicaid shortfall calculated above. The result shall be compared to the hospitals estimated DSH payments. If the estimated DSH payments exceed the DSH limit (Medicaid shortfall plus cost of uninsured) then the Department will reduce the hospitals DSH rate per day so that their DSH payments will equal the DSH limit. If necessary, retroactive adjustments will be made.

State Plan Att. 4.19-A, at 53, ¶ 7.g.iv., IL Opening Br. Ex. 2.[4]

Illinois argues that DAB No. 2863 "turned on" whether the "last sentence of this paragraph" "required [Illinois] to reconcile DSH payments to the hospitals' actual uncompensated costs incurred by the hospitals in providing care to Medicaid beneficiaries and the uninsured, during the relevant time period." Motion at 1-2. Illinois contends that it never intended the sentence to require it to do so. Rather, Illinois says that "because the payments were prospectively set," it included the sentence in the event that a hospital successfully appealed the amount of its DSH adjustment or other Medicaid payments, and the hospital's increased payments "caused it to exceed the prospectively-calculated hospital-specific DSH cap." Motion at 2-3 (citing McCurdy Decl., ¶¶ 10, 11, IL Opening Br. Ex. 3). In that case, Illinois "wanted the flexibility to be able to retroactively modify the payment to stay within the cap." Motion at 3.

According to Illinois, the Board erred in rejecting this interpretation of the State plan by deviating from the Board's long-established approach to evaluating a state's proposed interpretation of its state plan. Illinois says that the Board was required to give effect to the language of the plan as a whole by reading its State plan "comprehensively," "as a single comprehensive document," and not reading individual provisions in isolation. Motion at 4, 6. Illinois alleges that the "Board has not previously focused on the specific language present (or missing) in each provision of the State Plan, but has instead attempted to understand the overall intent of the provision, and how separate provisions of the plan interact." *Id.* at 5 (citing *Missouri Dep't of Soc. Servs.*, DAB No. 1189 (1990)). Illinois further alleges that the Board failed to consider Illinois' intent and past administrative practices, which show that the state consistently interpreted and implemented the provision, in keeping with the interpretation advanced on appeal. Illinois contends that the Board's decision imposed a new requirement, "that the State had an obligation to more clearly communicate its intent to CMS." Motion at 4.

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[4] DAB No. 2863 cited to this provision based on its location in the record: Exhibit 2 to Illinois' Opening Brief, at internal page 53. For greater clarity and in order to fully address the arguments in Illinois' Motion, we include the paragraph designation of this provision as shown in the exhibit. We note that CMS's Brief in Opposition to Illinois' Motion states that during the relevant period, the paragraph was designated VI.C.7.f.iv and that an amendment approved in 2001 changed the designation from subsection f to subsection g. CMS Brief at 2 n.1.

Discussion

1. Illinois misconstrues the Board's standards for determining whether to defer to a state's interpretation of its Medicaid state plan.

Illinois's Motion does not accurately describe the Board's process for evaluating whether a state has complied with the terms of its Medicaid state plan. As noted in DAB No. 2863, federal regulations use the terms "comprehensive" and "comprehensively" to describe Medicaid state plans. DAB No. 2863, at 2, 8-9. Specifically, 42 C.F.R. § 430.10 provides that a Medicaid state plan is required to be "a comprehensive written statement," in that it must set out "the nature and scope" of the state's Medicaid program, give "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," and contain "all information necessary for CMS to determine whether the plan can be approved to serve as a basis for [FFP] in the State program." Section 447.252(b), in turn, provides that a state "plan must specify comprehensively the methods and standards used by the agency to set payment rates" for inpatient hospital and long-term care facility services "in a manner consistent with §430.10 of this chapter." In other words, the State is responsible for ensuring that its plan provides sufficiently comprehensive information to make clear its methodologies.

In adjudicating a dispute about whether a state has complied with a particular payment methodology in its state plan, the Board is not, however, required to review the entire plan "comprehensively," as Illinois' Motion suggests. Indeed, the Board generally does not receive an entire state plan, and did not in this case, but rather reviews the parts of the state plan that the parties identify as relevant and submit for the record. In this case, the Board reviewed all parts of the State plan that Illinois and CMS chose to submit – and evidently Illinois did not believe that the entire plan was necessary to understand the relevant provisions. Nor does the Board ignore or gloss over the language in the state plan that establishes the methodology. To the contrary, the Board always looks first to the text – the specific language – of the state plan methodology and any related provision submitted by the parties. DAB No. 2863, at 9 (citing *South Dakota Dep't of Soc. Servs.*, DAB No. 934, at 4 (1988); *New Jersey Dep't of Human Res.*, DAB No. 2107, at 6-7 (2007)); *see also Missouri Dep't of Soc. Servs.*, DAB No. 1189, at 5-7 (1990). If the wording is clear, the Board will "apply the text according to its plain meaning." *New Jersey* at 6.

If state plan language is susceptible to more than one interpretation or silent about an issue, the Board will generally defer to a state's interpretation "if that interpretation is reasonable, is consistent with the purposes of the plan, and does not conflict with program requirements." *Texas Health and Human Servs. Comm.*, DAB No. 2176, at 3 (2008)

(citing *New Jersey* at 5; *Missouri*, DAB No. 1189, at 5); *see also South Dakota* at 4. In deciding whether a state's proposed interpretation is reasonable, the Board "will consider whether [it] gives reasonable effect to the language of the plan as a whole," but also recognizes that a "state's interpretation cannot prevail unless it is reasonable in light of the purpose of the provision and program requirements." *South Dakota* at 4. Similarly, in a case where the parties identified elements of the overall structure of the payment system as shedding light on the meaning and purpose, the Board considered whether the state's interpretation was reasonable in light of both the specific language of the relevant provisions and the organization of the plan. *Missouri*, DAB No. 1189, at 5.

"The Board will also consider evidence about the intent of the provision." *South Dakota at 4.* The Board will not defer to a state's interpretation of ambiguous language "unless it is reasonable in light of the purpose of the provision and program requirements." *Id.* The Board has also said that, lacking "documentary, contemporaneous evidence of intent," it "may consider consistent administrative practice as evidence" of whether the state "was applying an official interpretation of a plan provision or has advanced an interpretation only as an after-the-fact attempt to justify acting inconsistently with or simply ignoring its plan." *Id.*

2. The Board made no clear error of law or fact in evaluating whether Illinois complied with the terms of its Medicaid State plan.

Illinois also mischaracterizes the Board's analysis in DAB No. 2863. The decision did not depart in any way from the Board's longstanding practices in reviewing state plan provisions; nor did the decision simply turn on the wording of the last sentence in the State plan's DSH hospital-specific limit methodology. Rather, applying the principles for construing state plan language in this case, the Board first closely examined the full text of the State plan provision implementing the DSH hospital-specific cap statute. The decision described how the State plan language set out a multi-step methodology, which "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. . . .'" DAB No. 2863, at 14 (quoting IL Opening Br. Ex. 2, at 53). Based on the directly applicable wording, the Board explained, the process that Illinois used to calculate and apply each hospital's DSH payment limit during the relevant period (as described in Illinois' opening brief and the written testimony of a State official submitted as an exhibit) could not reasonably be considered consistent with the State plan. No language in the methodology provided for Illinois to compute the hospital-specific DSH limits using the State's upper payment limit methodology as it did, based on inflated and adjusted 1992 and 1994 data. The decision also discussed why Illinois' reliance on a 1994 State Medicaid Directors Letter as support for its approach was misplaced.

Furthermore, the Board took into account other provisions in the State plan in concluding that Illinois violated the plain language of the State plan methodology by including unreimbursed costs of insured patients ("bad debt") in its DSH limit calculations. Specifically, the Board considered the DSH reporting provisions and the State plan definition of uncompensated care charges, on which Illinois relied to support its inclusion of unreimbursed costs of insured patients in its calculations of the DSH hospital-specific limits. After considering the provisions, the Board determined that they did not excuse Illinois from violating the plain wording of the State plan methodology, which "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." DAB No. 2863, at 13 (quoting IL Opening Br. Ex. 2, at 53 (emphasis in decision)).

The decision further described why Illinois' interpretation of the last sentence of the DSH hospital-specific limit provision was unreasonable in light of the specific wording of the sentence *and* when the sentence was read in context. DAB No. 2863, at 13-14. Most importantly, no language in the sentence or the paragraph mentioned hospital appeals, referenced the hospital appeal process, or otherwise supported Illinois' interpretation of the term "[i]f necessary" to mean only in the event of a successful hospital DSH payment appeal. The Board therefore read the "retroactive adjustments" provision in context, as referring to the preceding sentences of the provision, which stated that Illinois would compare a hospital's DSH limit to its estimated DSH payments and reduce the hospital's DSH rate in the event that "the estimated DSH payments exceed the DSH limit. . . ." *Id.* at 14 (quoting IL Opening Br. Ex. 2, at 53). Based on the wording of the sentence providing for "retroactive adjustments" to be made when "necessary," the language to which it referred, and the absence of any mention in the provision to the hospital payment appeal process, the Board concluded that Illinois' interpretation could not be considered reasonable. *Id.* at 14. Conversely, the Board determined, on its face and when read in context, the language "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." *Id.*

Moreover, by pointing out that the hospital appeal provisions were in a different chapter of the State plan, the Board did not "suggest[] that DSH appeals are not referenced in the section regarding DSH adjustments" or read the DSH hospital-specific limit provision in isolation, as Illinois asserts. Motion at 6-8 (emphasis added). The decision in fact cited to the page of the DSH payment section that contained a reference to the hospital appeals procedures, and it was based on that reference that the Board surmised the appeals

procedures were set out in Chapter IX. DAB No. 2863, at 13 (citing IL Opening Br. Ex. 2, at 52). The purpose of noting that the appeals provisions were in a different chapter was to stress the lack of foundation for Illinois' interpretation: If a successful hospital payment appeal were the only basis for a retroactive adjustment to be "necessary," as Illinois argued, the organization of the plan would indicate how the "retroactive adjustments" provision was tied to the appeals process. Since the wording of the hospital-specific cap provision did not mention appeals, the alternative place to find language linking the processes or showing how they might be coordinated would be in the appeals provisions. Yet, those provisions were in a different chapter of the plan that Illinois did not even include with its submissions, indicating that there simply was no textual or organizational support for its interpretation of the "retroactive adjustments" provision.

Illinois now suggests that the Board should have deferred to its interpretation of the last sentence of the OBRA 1993 provision because "[o]nly one short paragraph . . . separates the reference" to the appeals procedures in Chapter IX and the "retroactive adjustments" language of the DSH hospital-specific limit methodology. Motion at 7. This argument would have us ignore the context in which the reference to the appeals procedures appears, paragraph 7.g.ii. That paragraph states that the "DSH status" of a hospital will not be affected by any other hospital's appeal of its ineligibility for DSH payment adjustments, or of its DSH payment adjustment amounts, "in accordance with Chapter IX." IL Opening Br. Ex. 2, at 52. Paragraph 7.g.ii does not set out the appeals procedures, refers only to maintaining DSH status, not to the calculation of DSH payments or limits, and does not in any way tie the appeals process to the "retroactive adjustments" language in the DSH hospital-specific limit methodology. Thus, the relative proximity in the State plan of a reference to the appeals procedures and the last sentence of the DSH hospital-specific limit methodology provides no support for Illinois' purported interpretation.

Illinois also argues that the Board failed to read the State plan as a whole because it "drew inferences from the State's use of the word 'retroactive' without giving due consideration" to evidence showing that the DSH hospital-specific limit provision did not use the same language that appeared in other sections of Illinois' State plan requiring retroactive reconciliation of payments to costs. Motion at 9-10. Illinois contends that the Board failed to take into account evidence showing that Illinois preferred to use prospective methodologies to pay hospitals, and almost always did so. Motion at 9-11. According to Illinois, the Board should have analyzed "the 'retroactive adjustment' language within the context of the State Plan as a whole, in which all hospital reimbursement is prospective unless expressly specified otherwise in detail . . . ." Motion at 11.

First, Illinois' general preference for using prospective payment methodologies to reimburse hospitals and its use of different language in other sections of its State plan when it "communicated its intent to reconcile payments to cost," Motion at 10, do not justify ignoring the specific language and context of the DSH hospital-specific limit methodology. As discussed in DAB No. 2863 and above, that language provided for a reconciliation of estimated payments to actual costs by requiring Illinois to compare a hospital's "DSH limit" to its "estimated DSH payments" and to make "retroactive adjustments" when "necessary." Moreover, as Illinois acknowledges, its State plan included other exceptions to the general use of prospective methodologies where specific policy considerations warranted. Such an exception was certainly called for in the case of the methodology implementing the DSH hospital-specific cap statute, the very purpose of which was to prevent states from making DSH payments that exceeded the hospitals' actual costs of providing medical care to the indigent and using the funds for other purposes. DAB No. 2863, at 2 (citing H.R. Rep. No. 103-111, at 211-12 (1993), *reprinted in* 1993 U.S.C.C.A.N. 378, 538-39).

Second, Illinois **did** use explicit language in specifying that retroactive adjustments will be made if necessary to DSH payments. What it did not do was provide any suggestion that only a single unusual event (a successful hospital appeal) could trigger the necessity to adjust retroactively. Thus, even under Illinois's claim that any use of retroactive methodologies in hospital payments will be expressly specified in detail, we would conclude that the express language should be applied as written and not expanded to add details not included in the provision.

Third, Illinois' reliance on the Board's decision in *Missouri Department of Social Services*, DAB No. 1189, is misplaced. That decision in part addressed whether Missouri's State plan permitted the State to grant trend factor increases to a provider's payment rates during the first year of the provider's operations. The Board determined that the language of the provision addressing new providers "did not specifically set forth trend factor formulas for newly constructed providers," but "implicitly recognized that such providers would receive trend increases" *Id.* at 6. The Board also found that CMS's reading to the contrary would create a permanent class of providers who would never obtain increased payments where all preexisting providers would obtain rate changes, and that CMS's proposed interpretation would be inconsistent with the entire payment methodology. Here, in contrast, Illinois' proposed interpretation: (1) contravenes the plan language, that retroactive adjustments would be made when necessary; (2) is not supported by the organization of the plan as a whole, which nowhere indicates that successful hospital appeals would be the only basis for retroactive adjustments to become necessary; and (3) is inconsistent with the purpose of adding the SPA -- to comply with the statutory mandate to limit DSH payments to **actual**, uncompensated Medicaid and uninsured patient costs.

3. The Board did not depart from its long-established standard for considering evidence of intent.

Illinois also argues that the Board erred by departing from its longstanding practice to look to evidence of a State's intent in determining whether a state's interpretation of its state plan is reasonable. Motion at 11, 14. "As in *South Dakota* and *New Jersey*," DAB No. 1090 (1989), Illinois says, it "submitted unrebutted testimony from a senior official" supporting the State's interpretation. Motion at 14. The official testified that Illinois consistently interpreted the "retroactive adjustments" provision as enabling "Illinois to adjust DSH payments if a hospital appealed for a higher DSH adjustment and won" and "never interpreted the State Plan language . . . as requiring the State to compare DSH payments to the hospitals' actual, [uncompensated] Medicaid and [uninsured] costs." *Id.* (quoting McCurdy Decl., ¶¶ 10, 11). Illinois further contends that contemporaneous communications with CMS in 1995 and 1996 show that Illinois informed CMS that it was using estimates in calculating the OBRA 1993 limit and that CMS approved the use of the estimates. The evidence of intent in its case, Illinois argues, was thus unlike the record in *Louisiana Department of Health and Hospitals*, DAB No. 2350 (2010), which also addressed whether State plan language implementing the OBRA 1993 limit required reconciliation of DSH payments to costs and to which DAB No. 2863 referred. Illinois additionally asserts that the Board erred by faulting it "for not more clearly specifying its intent regarding when a 'retroactive adjustment' might be necessary[.]" Motion at 16.

The importance of intent in evaluating a state's purported interpretation of its state plan arises only when there are two competing, reasonable interpretations of the language at issue or the state plan is silent with respect to the issue at hand. Where a state has advanced a reasonable interpretation of ambiguous language and there is no contemporaneous documentation of intent, the value of evidence demonstrating consistent administrative practice by the state is to distinguish an official, longstanding interpretation of the plan from an after-the-fact rationalization. To reach that question, the Board must first find that the state has offered an interpretation of the plan's language that reasonably reflects the terms of the provision at issue. In other words, the interpretation must plausibly address an ambiguity or gap in the wording which could have led each of the parties to have a different, good faith understanding of the meaning of the plan's language, and which does not contravene the purpose of the provision or other federal requirements.

These were the circumstances in the cases cited by Illinois where the Board determined that deference to the states' interpretations was appropriate. For example, in *New Jersey*, DAB No. 1090, the Board upheld the State's interpretation of language covering "non-medical" transportation services furnished under arrangement with the State Division of Public Welfare (DPW) to include services provided by the State Division of Youth and

Family Services, which had a written inter-agency agreement with the DPW. The Board reached its conclusion "taking into account all the circumstances," which included that the relevant language "was ambiguous enough so that the State reasonably construed it to permit such transportation, under the language of an arrangement with DPW," that "this was the State's consistent practice," and that the "costs were otherwise allowable." *New Jersey*, DAB No. 1090, at 2, 12-13. In *South Dakota*, the Board determined that the State's methodology for determining the number of patient days to be used in calculating the per diem rates for services reasonably interpreted ambiguous State plan language where the State presented undisputed evidence that, for every year but one, rates had not exceeded the facilities' actual costs, and the State's methodology related to a principle against which the figure could be objectively measured and which derived from the purpose of the provision. *South Dakota* at 5, 8-9.

In contrast, simply showing that the state failed to comply with the terms of its own state plan for an extended period cannot suffice to justify a claim that the state believed it could reasonably read the plan to suit its practice. That is the situation in which we find ourselves here. As described in the decision and summarized above, Illinois' purported interpretation is not reasonably supported by the wording of the State plan's hospital-specific cap provision. None of Illinois' arguments provides a reasonable basis to read into the requirement for making a retroactive adjustment "if necessary," a limitation to make a retroactive adjustment only if a hospital successfully appealed its DSH or other payment amount and, as a result of its increased payments, exceeded the previously-calculated DSH limit. Furthermore, as we have explained, Illinois' actual practices reveal that it failed to follow the plain language of the State plan's DSH hospital-specific limit methodology in other ways as well. For example, Illinois' inclusion of unreimbursed costs of insured patients in its DSH limit calculations expressly violated the plain language of the State plan methodology to include 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" in the "cost of uninsured" component of the hospital-specific limit. If anything, the fact that the State engaged in these other longstanding practices that plainly violated State plan provisions reinforces our conclusion that Illinois did not act on a good faith and reasonable contemporaneous interpretation of its State plan in the relevant regard either.

In addition, the record does not support Illinois' contention that "[c]ontemporaneous communications with CMS during the approval process for various 1995 State Plan amendments show that the State informed CMS that the OBRA 93 limit was calculated using '*estimates* for fiscal year 1996,' and that CMS approved the use of such estimates." Motion at 14-15 (citing IL Opening Br. Ex. 5, Letter from David Dupre to Robert Wright (Feb. 1996)) (emphasis added in Motion). The referenced February 1996 letter involved CMS's approval of SPA 95-14, not the amendment that implemented the hospital-specific

DSH limit provision, SPA 95-22. The letter summarized information that Illinois had provided to CMS in a November 17, 1995 letter, including estimated data for 1996 showing that the supplemental DSH payments to the University of Illinois at Chicago (UIC) Hospital would not exceed the OBRA 1993 limit. IL Opening Br. Ex. 4, at 2. Notably, CMS approved SPA 95-14 on February 16, 1996, many months before the end of the 1996 fiscal year, based on "the acceptability of the assurances" that Illinois had provided, including the "data indicat[ing] that total Medicaid inpatient payments to hospitals in State fiscal year 1996 will approximate 96.9% of allowable costs." IL Ex. 5, at 1. CMS also relied on Illinois' representation, based on its estimates for fiscal year 1996, that "the applicable DSH Limit" for UIC Hospital would "exceed[] DSH payments by $17.7 million." *Id*. at 2. While CMS thus approved SPA 95-14 based in part on Illinois' November 1995 estimates for fiscal year 1996, the approval did not excuse Illinois from retroactively adjusting DSH payments to actual costs to prevent the DSH hospital-specific limit from being exceeded.

Moreover, the Office of Inspector General (OIG) later found that Illinois had failed to follow its own methodology in estimating the hospital-specific limit for UIC Hospital for State fiscal year 1996. The OIG found that Illinois "inflated part of the Medicaid inpatient costs by more than 26 percent per year from 1992 to 1996, instead of a set 5 percent per year." Review of Illinois Medicaid Disproportionate Share Hospital Payments to the University of Illinois at Chicago Hospital, Oct. 2004, IL Opening Br. Ex. 7, at internal page 7. Had Illinois "correctly followed its own methodology," the OIG found, "it would have disclosed to CMS that payments to the hospital were estimated to exceed the hospital-specific limit by about $39.9 million for State fiscal year 1996." *Id.*

Illinois' attempt to rely on the differences in the State plan language and evidence of intent in its case and that of *Louisiana* to support its Motion also are unavailing. In *Louisiana*, the plain language of Louisiana's State plan established a retrospective system for making DSH payments under which the final, allowable payment amounts would be determined based on actual, audited costs. The Board also found in Louisiana's case that contemporaneous documentation in the record was at odds with the interpretation that Louisiana advanced on appeal. While it is true that the wording of Illinois' State plan and the record in its appeal differed from the wording of Louisiana's State plan and evidence in Louisiana's appeal, these differences do not justify reversing the disallowances in Illinois' case, where the State's purported interpretation of its State plan cannot reasonably be squared with the language that it chose to adopt or the purpose of the OBRA 1993 hospital-specific DSH cap.

Furthermore, we reject Illinois' characterization of DAB No. 2863 as "fault[ing] Illinois for not more clearly specifying its intent regarding when a 'retroactive adjustment' might be necessary," going "beyond prior Board decisions." Motion at 16. In support of this argument, Illinois relies on the Board decision in *South Dakota Department of Social Services*, DAB No. 934, discussed above, as well as the decisions in *Virginia Department of Medical Assistance Services*, DAB No. 1838 (2002), and *Missouri Department of Social Services*, DAB No. 1412 (1993).

The Board recognizes that states cannot be expected to include precise language in their state plans to address all conceivable payment issues that may arise in the administration of their Medicaid programs or to describe explicitly the purpose of each standard or methodology in their state plans. *See South Dakota* DAB No. 934, at 9 ("State plans are not as detailed as [CMS's] argument suggests they should be; nothing in the applicable federal provisions requires that the purpose of a provision be explained in the plan."). For these reasons, the Board developed and for decades has applied the procedures discussed above for evaluating whether to defer to a state's proposed interpretation where state plan language is ambiguous or silent. In the examples cited by Illinois, the state plan either was silent with respect to the issue raised on appeal (as in the case of the treatment of pharmacy copayments at issue in *Missouri*, DAB No. 1412), or ambiguous language in the plan was susceptible to more than one reasonable interpretation, including that proposed by the State (as in the case of the enhanced DSH payments at issue in *Virginia*, DAB No. 1838). The Board also determined in those cases that the state's proposed interpretations were consistent with the purposes of the program and did not result in a windfall in FFP to the state.

Here, in contrast, Illinois' purported interpretation cannot be considered reasonable in light of the directly applicable language of the State plan and would result in the type of windfall that Congress intended to preclude by enacting the OBRA 1993 hospital-specific cap legislation. Accordingly, Illinois is mistaken in arguing that the Board's decisions in other cases establish a clear error of law in DAB No. 2863.

4. We decline to consider the additional evidence submitted with Illinois' Motion.

Illinois' Motion alleges that the written declaration by a senior State official and other exhibits that Illinois previously submitted were "more than sufficient to support its position." Motion at 4. Nevertheless, Illinois proffered an additional exhibit (Exhibit 19) with its Motion, consisting of a second declaration by the same State official and five attachments (some of which are duplicative of its prior submissions) "to establish that the

Board's reading of the [State] plan was incorrect." *Id*. The additional documentation, Illinois says, "further explain[s] why the Board's decision does not give reasonable effect to the language of the plan as a whole, and does not comport with the State's consistent administrative practice." *Id.* at 6 n.2.

In order to ensure an orderly and efficient adjudication process, the Board's regulations at 45 C.F.R. Part 16 provide that it is the "appellant's responsibility" to submit to the Board an "appeal file containing the documents supporting the claim," that is, "those documents which are important to the Board's decision on the issues in the case." 45 C.F.R. § 16.8(a). Consistent with the regulations, the Board instructed Illinois and CMS, at the outset of Illinois' appeal, to "include all documents which would assist the Board in making findings of fact on disputed issues, as well as documents which provide necessary background information." Board Dkt. No. A-17-33, Acknowledgment of Notice of Appeal and Scheduling Order at 4; Board Dkt. No. A-17-34, Acknowledgment of Notice of Appeal and Scheduling Order at 4.

In light of the applicable regulations and instructions that the Board provides to the parties that appear before it, the Board will not reconsider a decision to receive additional evidence that could have been presented before the Board issued its decision, but was not. The Board has explained that a "motion for reconsideration is far too belated a context in which to undertake to present [additional] documentation," where the grantee "made no claim that this documentation was not available to it earlier in this process." Ruling on Request for Reconsideration of *Peoples Involvement Corp*., DAB No. 1967 (2005), Board Ruling No. 2005-2, at 2 (2005).[5]

In this case, the evidence submitted with Illinois' Motion was not the type of newly-discovered or previously unavailable evidence warranting reconsideration. The second declaration of Illinois' senior official, while dated after the Board's decision, consists of statements about Illinois' alleged understanding of the meaning of its State plan language and contemporaneous administrative practices during the relevant period, as well as arguments responding to the Board's decision. Furthermore, Illinois has not asserted that any of the documentation attached to the second declaration was newly discovered or previously unavailable. Accordingly, we decline to consider this evidence.

[5] Available at https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2005/rul20052.htm.

Conclusion

For the reasons stated above, we deny Illinois' Motion for Reconsideration.

/s/
Susan S. Yim

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member