Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

New Hampshire Department of Health and Human Services
Docket No. A-10-27
Decision No. 2399
July 13, 2011

DECISION

The New Hampshire Department of Health and Human Services (New Hampshire) appealed a disallowance by the Centers for Medicare & Medicaid Services (CMS) of $35,325,468 in federal Medicaid funding claimed by New Hampshire. CMS determined that New Hampshire had claimed costs for disproportionate share hospital (DSH) payments to 24 private hospitals for fiscal year 2004 (FY 2004) in excess of the hospital-specific DSH limits established under federal requirements and New Hampshire's Medicaid State Plan.

For the reasons explained below, we sustain the disallowance.

Statutory and regulatory background

Title XIX of the Social Security Act (Act) establishes the Medicaid program, under which the federal and state governments jointly finance the cost of providing medical assistance to certain needy and disabled persons.[1] Act §§ 1901, 1903. Each state that chooses to participate administers its own Medicaid program under broad federal requirements. The state sets the terms of its own "plan for medical assistance," or state plan, which must be approved by CMS. The state plan must specify the medical items and services covered by the state's program. Act § 1902; 42 C.F.R. § 430.10. The state plan must also describe the policies and methods used in setting payment rates for covered services. Act § 1902(13)(A); 42 C.F.R. §§ 447.201(b); 447.252. Once the state plan is approved, a state becomes entitled to receive federal reimbursement, or "federal financial participation" (FFP), for a percentage of its expenditures for covered medical care under the state plan. 42 C.F.R. § 430.10.

[1] The current version of the Act can be found 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.

In 1981, Congress amended the Act to require each state to provide for a process to determine payment rates under its state plan to "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. . . ." Pub. L. No. 97–35, section 2173(a)(1), amending section 1902(a)(13) of the Act. Such a hospital is referred to as a disproportionate share hospital (DSH). Section 1923 of the Act imposes specific payment obligations on states with respect to DSHs. In particular, it requires state plans to provide for "an appropriate increase in the rate or amount of payment" for "inpatient hospital services" furnished by DSHs, called a DSH payment adjustment. Act § 1923(a)(1)(B). A state may choose from several different types of methodologies to calculate DSH payment adjustments, including a methodology which "results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan . . . ." Act § 1923(c). After payments of FFP to states increased dramatically in the 1980s, Congress provided a formula for establishing a "DSH allotment" for each state, limiting the aggregate amount the state could claim for DSH payments in any year. Act § 1923(f).[2]

In 1993, Congress added section 1923(g) to the Act to provide for "hospital-specific" DSH payment limits. Section 1923(g)(1)(A) provides, among other things, that a DSH payment adjustment during a fiscal year may not exceed for any hospital—

> 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.

The costs described under section 1923(g)(1)(A) are referred to as uncompensated care costs (UCC).

1994 State Medicaid Directors letter

In 1994, CMS's predecessor agency, the Health Care Financing Administration,[3] issued a letter to all State Medicaid Directors addressing the DSH provisions in the 1993 amendment to the Act. NH Ex. 5. Attached to the letter was a summary of the agency's "interpretation of the key provisions of the new law" (letter and attachment collectively referred to as "1994 SMDL"). *Id.* (page 1 of summary). The 1994 SMDL stated that section 1923(g) "establishes facility specific limits on the amount of the payment

[2] It is undisputed that the DSH payments at issue here were within New Hampshire's state DSH allotment established by Congress for the relevant period.

[3] For ease of reference, we refer to both the Health Care Financing Administration and CMS as CMS.

adjustments that States may make to DSHs," and that the "annual DSH payment adjustment to each DSH may not exceed the limit for that hospital." *Id.* (page 2 of summary). The agency explained that a hospital-specific DSH limit should be calculated by adding: (1) the "Cost of Services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan;" and (2) the "Cost of Services to Uninsured Patients, less any cash payments made by them." *Id.* (page 3 of summary).

The 1994 SMDL then addressed the categories of costs that may be included in the calculation. First, the SMDL stated that, consistent with the legislative history of the statute, a state "may include both inpatient and outpatient costs in the calculation of the limit." *Id.* Second, the letter stated that, "in defining 'costs of services' under" the hospital-specific limits, CMS "would permit the State to 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.*

New Hampshire's approved Medicaid State Plan

For FY 2004, New Hampshire's approved Medicaid State Plan (State Plan) provided that the annual DSH payment for any "in-state general hospital or a special rehabilitation hospital which has a Medicaid utilization rate equaling or exceeding 1%" would be –

> equal to the cost of services furnished to Medicaid patients, less the amount paid under non-DSH payments under this plan, plus the costs of services provided to patients who have no health insurance or source of third party payments, which would apply to the service for which the individual sought treatment, provided in the hospital's fiscal year ending in the preceding calendar year, less the amount of payments made by these patients. This payment shall . . . not exceed a hospital specific maximum payment level of 6% of the gross patient services in the hospital's fiscal year ending in the preceding calendar year.

NH Ex. 13, at 5a, 5b. The six percent of gross patient services revenue limit described in the plan corresponded to the rate and basis of a provider tax called the "Medicaid Enhancement Tax" (MET) then imposed by New Hampshire. NH Rev. Stat. Ann. Chapter 84-A. This plan language was approved by CMS although, the parties agree, it does not specify "precisely how UCC is to be calculated." NH Br. at 9; CMS Br. at 13.

New Hampshire's DSH payment methodology

The FY 2004 DSH payments at issue were calculated using data collected on a form completed by each hospital in conjunction with the New Hampshire Hospital Association (NHHA). NH Br. at 4; NH Ex. 14; CMS Ex. 3. The NHHA is a trade association that performs advocacy work, research, and development for member hospitals. CMS Ex. 3, at 2. The form, titled "Medicaid Enhancement Tax Data Request" (MET form), gathered multiple categories of FY 2002 financial data from the hospitals. NH Ex. 14. The MET form also included a worksheet to determine a hospital's "Anticipated Medicaid Enhancement Tax/DSH Allowance" based on a cost-apportionment formula.[4] *Id.* Using the worksheets, a ratio labeled "RCC (Ratio Cost to Charge)" was developed for each hospital. NH Ex. 14; *see also* NH Exs. 8, 9. That ratio was multiplied against "Bad Debt" ("Expressed as charges, net of recoveries") and "Charity Care" ("Expressed as charges"), and "Medicaid Charges" to determine, respectively, each hospital's "Cost of Uncompensated Care" and "Medicaid Cost." *Id.* The hospital's non-DSH "Medicaid Payments" were then subtracted from its "Medicaid Cost," resulting in "Medicaid Loss." "Medicaid Loss" was added to the "Cost of Uncompensated Care" to produce "Total Loss." *Id.* The hospital's DSH payment adjustment was then identified as equal to the lesser of its "Total Loss" or six percent of its "Gross Patient Service Revenue." *Id.*

The OIG review and CMS's disallowance

In 2005, the Department of Health and Human Services, Office of Inspector General (OIG), began a review of New Hampshire's FY 2004 DSH payments to determine whether they complied with the hospital-specific limit requirements set forth in section 1923, New Hampshire's State Plan, and the 1994 SMDL. NH Exs. 18, 20. In its July 2007 final report, the OIG determined that $70,650,936 ($35,325,468 FFP) of the payments was unallowable because, for 24 DSHs, New Hampshire "did not properly determine the hospitals' allowable costs in accordance with the Medicare principles of cost reimbursement," as required under the 1994 SMDL. NH Ex. 20, at i.

The OIG concluded that the cost-to-charge ratios that New Hampshire used to calculate the DSH payments "were inflated because they (1) overstated costs (numerator) by including unallowable costs and (2) understated charges (denominator) by using net, rather than gross, patient services revenue." *Id.* at 5. Specifically, the OIG found that New Hampshire used the operating expenses that the hospitals reported on their FY 2002

[4] New Hampshire includes in the text of its brief a formula that New Hampshire describes as the "calculation . . . performed for each hospital." NH Br. at 4-5, *citing* NH Ex. 25, Declaration of James P. Fredyma. That formula, however, does not describe the calculation as it is presented on the MET form worksheet, other primary source evidence, or in the OIG audit findings. NH Exs. 8, 9, 14. We therefore rely on the primary source evidence to describe the calculation.

audited financial statements as the cost figures in the ratios. These operating expenses, the OIG found, "included costs, such as bad debts, meals sold to visitors, gift shops, and entertainment, that are not recognized under the Medicare principles of cost reimbursement because they are not related to patient care." *Id.* at 5, *citing* 42 C.F.R. § 413.80(c); CMS Provider Reimbursement Manual (PRM).[5] Further, the OIG determined, the "State agency understated the denominators in its cost-to-charge ratios" by using net, rather than gross, patient services revenue. *Id.* at 6. Net patient services revenue, the OIG stated, included "deductions for contractual allowances and other discounts." *Id.* "Because the numerators were larger and the denominators were smaller than they would have been if the State agency had applied Medicare principles of cost reimbursement," the OIG determined, "the resulting ratios were inflated." *Id.* Consequently, the OIG concluded, when the ratios were multiplied against each hospital's total gross charges for services provided to Medicaid and uninsured patients, the resulting UCC figures also were inflated. *Id.*[6]

On October 22, 2009 CMS issued a determination disallowing $35,325,468 in FFP for New Hampshire's FY2004 DSH payment claims based on the OIG's audit findings and recommendations.

New Hampshire timely appealed.

Analysis

Below we first discuss why the methodology on which New Hampshire relied to calculate the DSH payments in dispute was not reasonable under section 1923(g)(1)(A) of the Act and the State Plan. We then explain why we find the methodology used was not previously approved by CMS, as alleged by New Hampshire. Finally, we explain why we reject New Hampshire's argument that the disallowance should be reversed because it is inconsistent with prior CMS statements and actions in other matters.

1. The methodology on which New Hampshire relied to determine the DSH payments at issue was not reasonable.

As New Hampshire points out, neither section 1923(g)(1)(A) nor New Hampshire's approved State Plan specified how UCC would be calculated. New Hampshire argues,

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[5] Section 413.80(c) is from the Medicare regulations on reasonable cost reimbursement in effect during the relevant period and addresses the general Medicare principle that bad debts are reductions in revenue and not to be included in allowable costs. The provision at 42 C.F.R. § 413.9, "Cost related to patient care," establishes the principle that payments must be "based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries."

[6] To determine the disallowance amount, the OIG recalculated each hospital's UCC "in accordance with the Medicare principles of cost reimbursement," using data from the hospitals' FY 2002 audited Medicare cost reports. NH Ex. 20, at 6.

therefore, that New Hampshire was not required to use a cost-to-gross-charges ratio but had the flexibility to use a different method. New Hampshire argues that it used a reasonable method, consistent with the basic Medicare principle of cost apportionment that "[t]otal allowable costs of a provider are apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries." NH Br. at 24, *citing* PRM at ch. 22, § 2200.1; *see also* 42 C.F.R. §§ 413.50, 413.53(a) ("Total allowable costs of a provider will be apportioned . . . so that the share borne by the program is based upon actual services received by program beneficiaries.") .[7] New Hampshire asserts that the auditors appeared to recognize this by stating that the "State agency must use an allocation process to determine a hospital's actual costs of providing services specifically to Medicaid and uninsured patients" and that a state "may" determine these costs using a cost-to-charge ratio of the hospital's total allowable costs to its total gross charges. *Id. citing* Audit Report at 2.

We agree that New Hampshire had a certain degree of flexibility under the statute and State Plan and was not required to use a cost-to-charge ratio to apportion allowable costs among groups of patients. Any methodology chosen for determining allowable costs and apportioning them among groups of patients, however, had to be a reasonable method of determining UCC, consistent with the statute and State Plan. Below, we first explain general principles of allocability and use of ratios in allocating costs among cost objectives. We then explain what rationale justifies using a cost-to-charge ratio in Medicare, how New Hampshire's methodology differed, and why that methodology was not reasonable under the statute and State Plan.

A. New Hampshire's methodology was inconsistent with principles of allocation.

In general, a cost is allocable to a cost objective (or cost center), such as a specific function or project, if the goods or services involved are chargeable or assignable to the cost objective or center in accordance with the relative benefits received or based on some other equitable relationship. *See, e.g.*, 45 C.F.R. Part 74, App. E, ¶ III, D. 1; NH Ex. 15, at 17. A ratio may be used to distribute a pool of costs if the pool of costs bears a rational relationship to a quantifiable distribution base. For a ratio to equitably allocate a group of costs, the numerator of the ratio (total costs of a particular type) must bear at least roughly the same relationship to the denominator (or distribution base) as the unknown subset of the costs bears to the part of the distribution base that is identifiable to that specific cost objective. Stated differently, the distribution base must be a suitable one for assigning the pool of costs to a particular cost objective according to the relative benefits accrued, a traceable cause and effect relationship, or a logical and reasonable

[7] The Medicare regulations define "apportionment" to means "an allocation or distribution of allowable cost between the beneficiaries of the Medicare program and other patients." 42 C.F.R. § 413.53(b).

connection. *See, e.g.,* 45 C.F.R. Part 74, App. E, ¶ V.B.3.b. Thus, for example, square footage is a commonly accepted distribution base for space-related costs.

Moreover, as indicated by the basic Medicare principle on which New Hampshire relies, the pool of costs to be distributed must be defined and cannot include unallowable costs. Under the Medicare regulations addressing the apportionment of allowable costs, reimbursement under the program first "involves a determination of each provider's allowable costs for producing services," and then a determination of the "share of these costs which is to be borne by Medicare." 42 C.F.R. § 413.50(a)(1)-(2).

Medicare's use of a cost-to-charge ratio to apportion allowable costs of services among groups of patients is premised on the correlation between the allowable costs of providing services to patients and the charges for those services. As the Medicare regulations state, "[i]mplicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services." 42 C.F.R. § 413.53(b). Under this methodology, "the provider's own charge structure and method of itemizing services for the purpose of assessing charges is utilized as a measure of the amount of services received and as the basis for allocating responsibility for payment among those receiving the provider's services." 42 C.F.R. § 413.50(h). To further ensure the integrity of the methodology, the term "charges" is used to refer to "the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services." 42 C.F.R. § 413.53(b). Accordingly, all charges used in the development of an apportionment ratio must "be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions." PRM § 2202.4. This ensures that charges are related consistently to the allowable costs of services and uniformly applied to all patients. *Id.*

The methodology on which New Hampshire relied to calculate the DSH payments, in contrast, did not limit the pool of costs distributed to allowable costs of providing hospital services to patients, used "net services revenue" (i.e., charges reduced by discounts and retroactive adjustments) as the distribution base, and applied the resulting ratio to a different base (gross charges). As discussed below, this method was inconsistent with the statute, State Plan, and CMS guidance, for three reasons: the method resulted in distributing to UCC certain costs that were not reasonably considered the costs of providing hospital services to patients; the distribution base did not bear a reasonable relationship to the costs distributed; and the application of the resulting ratio to a different base skewed the allocation of costs to Medicaid and uninsured patients.

B. New Hampshire's method resulted in distributing to UCC costs that were not the costs of providing inpatient or outpatient hospital services to patients.

To determine what is the allowable pool of costs to be distributed to Medicaid and uninsured patients in order to qualify as UCC, we look first to the text of section 1923(g)(1)(A) of the Act. If the wording of the Act "clearly and precisely addresses the issue, then our role is to enforce the statute according to its terms." *Virginia Dept. of Medical Assistance Services*, DAB No. 2084, at 8 (2007), *aff'd, Commonwealth of Virginia v. Johnson*, 609 F.Supp.2d 1 (D.D.C. 2009). The meaning of statutory language, however, "cannot be determined in isolation, but must be drawn from the context in which it is used." *Deal v. United States*, 508 U.S. 129, 132 (1993).

In this case, section 1923(g)(1)(A) provides that to determine a hospital-specific DSH payment limit for any year, a state must first ascertain "the **costs** . . . of furnishing **hospital services**" by the hospital to individuals who are eligible for Medicaid or who have no health insurance or other source of third party coverage. (Emphasis added.) The state must then deduct from this amount any non-DSH Medicaid payments received by the hospital and any payments received from uninsured patients. *Id.* Tracking the language of the Act, Attachment 4.19-A, p. 5b of New Hampshire's State Plan provided that a hospital-specific DSH payment limit would be derived by determining "the **cost of services** furnished to Medicaid patients, less the amount paid under the non-DSH payments under [the State Plan], plus the **costs of services** provided to patients who have no health insurance or source of third party payments . . . less the amount of payments made by these patients." NH Ex. 6 (emphasis added). Thus, section 1923(g)(1)(A) limits DSH reimbursement to costs of furnishing "hospital services" to Medicaid and uninsured patients. The State Plan, similarly, expressly provides reimbursement only for costs of furnishing services to Medicaid and uninsured patients in deriving UCC.

Taking into account the legislative history and the context of the hospital-specific DSH payment limit statute, the Board previously has held that the term "hospital services" in section 1923(g)(1)(A) has a specialized, technical meaning. *Missouri Dept. of Social Services*, DAB No. 2161 (2008) (holding that community mental health centers were not "hospital services" within the meaning of the statute); DAB No. 2084, at 8 (holding that physician services billed by a separate legal entity were not "hospital services" within the meaning of the statute). As the Board noted in these decisions, the House Conference Report accompanying the 1993 Amendment stated that the amount of a hospital's annual DSH payment is limited to the costs incurred by the hospital in furnishing "inpatient and outpatient services to Medicaid and uninsured patients," less payments from Medicaid

(other than DSH payments) and less payments from uninsured patients. H.R. Conf. Rep. No. 103-213, at 835 (1993), *reprinted in* 1993 U.S.C.C.A.N. 1088, 1524.[8] Thus, DSH payments are not meant to offset **all** of the costs that might be incurred by a DSH in addressing the needs of indigent patients, nor are DSH payments "meant to provide reimbursement for the costs of any service provided in or by a hospital, as might be thought from the ordinary sense of the term (hospital services)." DAB No. 2161, at 15.

Consistent with the legislative history of section 1923(g)(1)(A), the 1994 SMDL advised states "that a cost could be included in the facility-specific limit calculations only if it was an 'allowable' cost of an inpatient hospital service or outpatient hospital service." *Id.* at 2. The 1994 SMDL further provided that "in defining 'costs of services' under this provision, [CMS] would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition" did not "exceed the amounts that would be allowable under the Medicare principles of cost reimbursement." NH Ex. 5 (p. 3 of summary). "The Medicare principles," the SMDL stated, were "the general upper payment limit under institutional payment under the Medicaid program." *Id.* At the time the SMDL was issued, the upper payment limits for "institutional" payment were caps on payments for "inpatient hospital services" and "outpatient hospital services." *See* 42 C.F.R. §§ 447.253(b), 447.272, 447.321 (1994). Thus, CMS explained, its "interpretation of the term 'costs incurred' [was] reasonable because it provide[d] States with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs." NH Ex. 5 (p. 3 of summary).

New Hampshire argues that federal law did not require Medicaid DSH calculations to be limited by Medicare cost principles during the period at issue. NH Br. at 13. There is no mention of the Medicare principles in the text or legislative history of section 1923(g), New Hampshire contends. Further, New Hampshire argues, the 1994 SMDL "merely conveyed" what CMS "would permit," that is, "would plan to say in a rule that it was planning to issue." *Id.* at 15. Moreover, New Hampshire continues, even if CMS intended the 1994 SMDL to be binding, it "did not take the necessary rulemaking steps to make it so" by meeting the notice and comment requirements under the Administrative Procedure Act (APA), 5 U.S.C. § 553. *Id.*; NH Reply at 3. New Hampshire avers that sustaining the disallowance "would also violate basic principles of due process," which require "clear notice to the State of the standards to which it is expected to conform its behavior." NH Br. at 18.

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[8] Further clarifying the meaning of the term "hospital services" in section 1923(g)(1)(A), the subsequently-enacted section 1923(j)(2) of the Act directs states to submit independent audits verifying that "[o]nly the uncompensated care **costs of providing inpatient hospital and outpatient hospital services** . . . are included in the calculation of the hospital-specific limits." (Emphasis added.) The DSH auditing and reporting requirements at section 1923(j) were added under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, 117 Stat. 2431.

The Board previously recognized that the 1994 SMDL is "an official CMS interpretation of the relevant language in section 1923(g)(1)(A)," which "timely and adequately notified" states of the agency's construction of the statute. DAB No. 2084, at 12, *aff'd* 609 F.Supp.2d at 9-12. Notice and comment rulemaking under the APA does not apply to interpretive rules. 5 U.S.C. § 553(b).

This Board defers to CMS's interpretation of an ambiguous statutory provision if that interpretation "is reasonable and the grantee had adequate notice of the interpretation or, in the absence of notice, did not reasonably rely on its own contrary interpretation." *Massachusetts Executive Office of Health and Human Services*, DAB No. 2218 (2008), *citing Alaska Dept. of Health and Social Services*, DAB No. 1919, at 14 (2004); *see also Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87, 99 (1995) (a guideline published in a CMS program manual was a "prototypical example of an interpretive rule issued by an agency to advise the public of its construction of the statutes and rules it administers"). While there is no mention of the Medicare principles in the text or legislative history of section 1923(g), New Hampshire has presented no evidence that Congress has at any time rejected the use of Medicare cost principles to calculate UCC for purposes of determining hospital-specific limits on DSH payments.[9] In addition, the 1994 SMDL expressly stated that "until" regulations implementing the statute were published, the summary should be considered the agency's official interpretation of the new statute. NH Ex. 5, at 1.

Upholding the Board's decision in *Virginia Dept. of Medical Assistance Services*, the district court found that when CMS issued the 1994 SMDL, "it is clear that the agency . . . tied [DSH] reimbursement to 'the amounts that would be **allowable** under the Medicare principles of cost reimbursement.'" 609 F.Supp.2d at 10, quoting DAB No. 2084 (emphasis in original). Moreover, the court sustained the Board's determination that the 1994 SMDL gave "fair warning" to the states of the agency's interpretation of the hospital-specific DSH payment limit statute. 609 F.Supp.2d at 12, 14. Accordingly, New Hampshire's arguments that the 1994 SMDL was a legislative rule subject to notice and comment rulemaking and that New Hampshire was not provided notice that Medicare cost principles would limit the DSH payments are simply unfounded.

New Hampshire further argues that the costs included in the numerator of the ratio should not be limited to costs allowable under Medicare principles because all of the operating expenses "were legitimate costs that the hospitals actually incurred in the course of engaging in the provision of medical care to Medicaid patients and the uninsured (among others)." NH Br. at 19. Further, New Hampshire argues, "Unlike other types of disallowed costs that the Board has addressed, there is no dispute that these were hospital

[9] New Hampshire points out that in 2001 CMS chose not to adopt a facility-specific Medicaid upper payment limit (UPL) regulation based on what a provider would have been paid using Medicare payment principles. This choice, however, was independent of, and did not contradict, CMS's interpretation of the hospital-specific DSH limits as set forth in the 1994 SMDL. NH Br. at 13-16, *citing* 66 Fed. Reg. 3148 (2001).

costs, and not the costs of other services." NH Reply at 11. New Hampshire objects to the OIG's use of the hospitals' Medicare cost reports to determine the costs to be included in the numerator, contending that the OIG did so "[s]imply because it was convenient." NH Br. at 19-20.

The issue here is not, however, whether the costs were "legitimate" costs incurred by the hospitals. Instead, the issue is whether the costs were allowable costs of furnishing inpatient or outpatient hospital services to patients. New Hampshire fails to point to any provision in its State Plan that provided for inpatient or outpatient hospital services costs to include the costs that the OIG identified as unallowable (e.g., advertising, gift shop, entertainment, and meals provided to visitors). To the contrary, New Hampshire's approved State Plan for the period at issue provided for Medicaid payments for inpatient and outpatient hospital services to be based, respectively, on Medicare's prospective payment methodology and Medicare cost reimbursement principles. CMS Ex. 28, at 6; CMS Ex. 29; CMS Ex. 30, at 1. Nor did New Hampshire show that it adopted a different definition of hospital services costs for DSH calculation purposes. Indeed, as discussed below, the record shows that New Hampshire itself had no written policies specifying how to calculate UCC, and essentially abdicated its responsibility to determine hospital-specific DSH payments to the NHAA. Accordingly, New Hampshire could not reasonably include in its DSH payment calculations the costs identified by the OIG as unallowable.

The inclusion of bad debts in the numerator of the cost-distribution ratio likewise was improper. New Hampshire argues that even if Medicare cost principles applied here, recognizing bad debts in the numerator was appropriate because "bad debts attributable to the deductibles and coinsurance amounts are reimbursable under [Medicare]." NH Br. at 21, *citing* 42 C.F.R. § 413.89(a). This argument fails to take into account that while Medicare cost principles do provide for payment for a specific type of bad debt, New Hampshire apparently included all bad debts in the numerator (not only the type of bad debt recognized under Medicare) and also included them in the denominator. NH Ex. 20, at 10. As explained in the OIG's final report, New Hampshire first included bad debts in DSH operating expenses, in the numerators of the apportionment ratios. Second, New Hampshire again included bad debts as charges that were multiplied by the ratio. By removing bad debts from the numerators of the ratios, the OIG "eliminated [New Hampshire's] duplicate reimbursement for bad debts," consistent with 42 C.F.R. § 413.80 (subsequently recodified at 42 C.F.R. § 413.89(c)). *Id.* As the regulation explains, Medicare's treatment of bad debts is consistent with normal accounting treatment: bad debt allowances "represent reductions in revenue," and are not included in allowable costs because "[s]uch costs have already been incurred in the production of the services." 42 C.F.R. § 413.89(c). Merely because Medicare might make payments for some

specific types of bad debt does not mean bad debts constitute costs for purposes of a cost-to-charge ratio. Thus, New Hampshire's inclusion of bad debts as an **additional cost** in the numerator of the ratio improperly inflated the allowable pool of costs to be distributed.

In sum, we conclude that, by including unallowable costs in the numerator of the cost-distribution ratio, New Hampshire impermissibly inflated the ratio and effectively allocated to UCC costs that exceeded the uncompensated "costs incurred . . . of furnishing hospital services" to Medicaid and uninsured patients under section 1923(g)(1)(A) and the State Plan. The OIG thus used the hospitals' Medicare cost reports to identify the costs the OIG determined were allowable for hospital inpatient and outpatient services. NH Ex. 20, at 6. While New Hampshire objected to the OIG's calculation of the numerator for each hospital based on the hospital's Medicare cost report, New Hampshire failed to identify any additional allowable costs of furnishing inpatient or outpatient services to include in the numerator for any hospital.

C. There is no logical correlation between the pool of costs in the numerator of New Hampshire's ratio and the distribution base in the denominator.

As indicated above, use of a cost-to-charge ratio is based on the assumption that there is a logical correlation between the costs of providing particular services and the charges for those services. New Hampshire has not explained how the rationale underlying use of a cost-to-charge ratio would still be valid if the denominator does not, in fact, reflect the hospital's actual charges for the services, but instead reduces those charges by discounts and retroactive adjustments (as the net services revenue figure does). Discounted rates, for example, would not necessarily be applied to all services of a particular type, but only to those provided under a specific contract. Use of such net services revenue as a distribution base could therefore distort the apportionment of costs. For example, if the discounts applied only to one group of commercially insured patients, fewer costs would be allocated to that group than to another group of patients (for example, uninsured patients), even if the same services were provided.

Thus, we conclude that the use of net patient services revenue, as opposed to gross charges, in the denominator of New Hampshire's apportionment ratio improperly inflated the ratio, resulting in an overstatement of UCC for each DSH.

D. New Hampshire improperly applied its ratio to a distribution base different from the one used to calculate the allocation ratio.

Use of an allocation ratio also assumes that the ratio will be applied to a base that is composed of the same elements as the distribution base used to calculate the ratio in the first instance. Thus, the Board has upheld disallowances of claims for indirect costs under a grant where a grantee applied an approved indirect cost rate (a ratio of indirect to

direct costs, expressed as a percentage) to a direct cost base that included cost elements that were not included in the distribution base used to calculate the rate. *New Mexico Children, Youth and Families Department*, DAB No. 2159 (2008); *Texas Health and Human Services Commission*, DAB No. 2136 (2007); *University of California*, DAB No. 763 (1986).

Here, similarly, while the cost-apportionment ratio used net services revenue (as opposed to gross charges) as the distribution base (denominator), the ratio was applied to a different base (gross Medicaid charges) to determine the costs of furnishing services to Medicaid patients. Moreover, the ratio was applied to a different distribution base to calculate the component of UCC related to the uninsured. Instead of being applied to net services revenue associated with uninsured patients, the ratio was applied to "bad debt (charges net of recoveries)" plus "charity care." NH Exs. 8, 9, 14.

E. New Hampshire's evidence regarding greater costs of serving Medicaid and uninsured patients does not justify its methodology.

New Hampshire argues that it was reasonable to use net patient services revenue in the distribution base of the apportionment ratio and to apply the ratio against the gross Medicaid revenue figure because Medicaid and uninsured patients "are more expensive to treat, and the actual services received by these patients cost more to provide." NH Br. at 26, *citing* NH Exs. 7, 10. For example, New Hampshire argues that, in comparison to high-income patients, low-income patients more frequently use expensive services, such as emergency room services, and consume more hospital resources in connection with any given service. According to New Hampshire, the ratio it used "attempted to take into account" the state's belief that "on average, there is a greater cost for use of any single service when it is received by a Medicaid or uninsured patient." NH Ex. 25, at ¶ 5; *see also* NH Br. at 26, NH Reply at 12. New Hampshire argues that the "oversimplifying effects of the ratio of cost to charges," is one reason why such ratios "do not perform well as a tool to analyze the costs of individual patients.'" NH Br. at 25, quoting Wyoming Healthcare Commission, "Unreimbursed Catastrophic and Trauma Care Report" Oct. 28, 2004, App. A (NH Ex. 16, at 4).

While New Hampshire proffers studies that support the general proposition that Medicaid and uninsured patients are more expensive to treat than other patients, New Hampshire has provided no data to support its self-described "belief" that the additional costs of treating Medicaid and uninsured patients would not be sufficiently accounted for through a hospital's own charge structure and system of itemizing services.[10] That is, New Hampshire has not provided any evidence to show that, for example, a hospital's specific charges for items and services furnished during an emergency room visit would not

[10] We note that one of the two studies cited by New Hampshire was limited to examining the relative costs of patient groups in health maintenance organizations, concluding that "[a]lthough the cost ratios could be the same in fee-for-service plans as in HMOs, we have no evidence one way or the other." CMS Ex. 7, at 10.

sufficiently reflect the costs of the resources used by different patients. Further, even if we were to accept in principle that a provider's charge structure would not take into account the higher costs of providing hospital services to Medicaid and uninsured patients, New Hampshire has failed to show how the use of net patient services revenue in the denominator of the distribution ratio would reasonably quantify the alleged "greater cost of their use of any single service that might be charged out at the same flat, gross rate to all users." NH Br. at 26. New Hampshire acknowledges that its methodology was "not precise," arguing nevertheless that it "reflected a reasonable proxy for the higher costs of these patients." *Id.* In light of the lack of evidence to support New Hampshire's argument and methodology, we cannot agree.

Furthermore, the study that New Hampshire quoted as stating that cost-to-charge ratios "do not perform well" when looking at "**individualized** patients," simultaneously stated that the "literature on hospital costs has shown that costs calculated using the [ratio-of-cost-to-charge] method are a **good** approximation for true costs when **groups of patients** are compared (recommended comparisons include comparing . . . groups of patients in one hospital with other groups of patients in that hospital)." NH Ex. 16, at 4 (emphasis added). Because DSH payment limits are developed to reflect the uncompensated costs of hospital services furnished by a hospital to two different patient groups, this study thus indicates that a cost-to-charge ratio would perform well to derive UCC. In any event, if New Hampshire believed that use of a cost-to-charge ratio would not sufficiently identify UCC for its DSH hospitals, then New Hampshire could have selected a more reliable and accepted methodology than the one used to determine the DSH payments at issue.

As we discuss below, moreover, New Hampshire has not provided any evidence to show that it intentionally relied on the use of net patient services revenue in the distribution base of the apportionment methodology to compensate for higher costs attributable to Medicaid and uninsured patients. Thus, we agree with CMS that New Hampshire's argument about higher costs of the Medicaid and uninsured is a post-hoc rationalization. Therefore, it is not a relevant factor in interpreting the State Plan (which is, in any event, silent on what methodology would be used to calculate UCC).

In sum, we conclude that New Hampshire has failed to show that the methodology on which it relied to calculate UCC was based on reasonable assumptions and was a valid method to apportion allowable costs among patient groups. Indeed, even if we were to conclude that the 1994 SMDL's guidelines on the DSH payment limits were without force or effect (which we do not), the methodology on which New Hampshire relied to calculate the disputed DSH payments cannot reasonably be understood as properly identifying "the costs incurred . . . of furnishing hospital services" to Medicaid and uninsured patients under any reasonable interpretation of section 1923(g)(1)(A) of the Act.

2. CMS did not previously approve the DSH payment methodology.

New Hampshire argues that the disputed DSH payments should be allowed because CMS previously approved the DSH payment methodology. New Hampshire contends, "CMS had a full opportunity to review and understand" the methodology, which was "in place since 1995." NH Br. at 8, 10, *citing* 1995-2003 Plan at p. 5b; NH Ex. 25, at ¶¶ 3, 6-7. According to New Hampshire, it "has always behaved transparently with CMS in connection with its DSH and other Medicaid methodologies, and it believes that CMS has always understood all material aspects of its UCC calculations." *Id. citing* NH Ex. 25, at ¶ 7. New Hampshire alleges that on "multiple occasions" it provided CMS staff "documents showing the ratio calculations, including the use of operating expenses in the numerator and net patient services revenue in the denominator." NH Br. at 10, *citing* NH Ex. 25, at ¶ 7; NH Exs. 8, 9. Moreover, New Hampshire avers that in 2003-2004, CMS thoroughly evaluated New Hampshire's DSH program in connection with CMS's review of several proposed State Plan amendments (SPAs) and the MET. According to New Hampshire, its discussions with CMS about the SPAs and the MET "culminated in a global agreement in early 2004," which "must be understood to encompass approval of the State's approach to determining UCC, at least through state fiscal year 2005." NH Br. at 11-12.

The record does not support New Hampshire's arguments. Prior to the OIG audit, New Hampshire's own Office of Legislative Budget Assistant (OLBA) conducted audits of the State's DSH program. CMS Exs. 1, 2, 4, 5. The OLBA audits found that New Hampshire had "delegate[d] the task of performing the specific details, methodology, and final DSH calculations to the [NHHA]." CMS Ex. 2, at 17-18; CMS Ex. 4, at F-23-24.

OLBA further found that there was "no contract or written agreement related to the work performed on [New Hampshire's] behalf by the NHHA." *Id.* Moreover, OLBA determined, "Neither the NHHA nor [New Hampshire] verifie[d] the financial information submitted by the hospitals forming the basis of the calculation and [New Hampshire did] not perform a review of the NHHA calculations to ensure accurate computations." *Id.* OLBA's review "revealed certain errors and other inconsistencies that indicate[d] the accuracy of the calculations would have benefited from a more robust review and approval process." *Id.* Consequently, OLBA recommended that New Hampshire "implement policies and procedures to review and verify" the data and payments and that it "formalize its agreement with the NHHA to ensure that the process remains controlled and reliable." *Id.*

According to OIG audit meeting reports, New Hampshire officials in August 2005 "confirmed that the State agency [did] not have written procedures for the review and verification of the data provided by NHHA," did "not know who developed or approved the calculation methodology," was unsure whether the preparers of the MET Data

Request Forms certified the information on the forms with signatures, and did not know if the hospitals used audited or unaudited statements to fill out the reports.[11] CMS Exs. 1; 9, at 4. Furthermore, New Hampshire did "not have procedures or a list of definitions for items to be reported on the MET Tax Data Request Form." CMS Ex. 9, at 4. When New Hampshire representatives reviewed the form with OIG auditors, they indicated that "it would be best to contact each hospital to verify what is included in their calculations." *Id.* New Hampshire representatives were "not sure if outpatient settlements are included in the Medicaid payments, and they have never looked at a hospital[']s accounting system to follow a claim." *Id.* at 5. Thus, the evidence shows that New Hampshire officials themselves did not fully understand all material aspects of the FY 2004 DSH payment calculations at the time the payments were made, and the NHHA and the hospitals themselves essentially controlled the DSH payment calculations.

Furthermore, the documentation that New Hampshire says it provided to CMS on-site staff failed to clearly identify how the hospital-specific DSH payment adjustments were calculated or to define the MET form's significant terms. NH Exs. 8-9. For example, the documentation did not indicate that the sources of the hospitals' financial data were not Medicare cost reports, reflecting allowable inpatient and outpatient hospital services costs, but instead, financial statements that included operating costs that were not patient care costs. NH Exs. 8-9. In our view, the documentation is not adequate to show that CMS' on-site staff had sufficient information to have understood the extent to which the calculations on which New Hampshire relied deviated from a true cost-to-charge apportionment methodology. Indeed, while New Hampshire argues that "it had not purported to use a cost-to-charge ratio, but instead had used a ratio of costs to net revenues," the forms themselves identified the distribution ratio used as a "ratio cost/charges (RCC)." NH Br. at 7; NH Exs. 8, 9, 14.

Moreover, the record does not show, nor does New Hampshire allege, that CMS's on-site representatives were asked or had the authority to approve or disapprove the DSH UCC methodology or that the purpose of their review was to determine whether the methodology was approvable. Indeed, New Hampshire's Controller describes in his declaration the CMS representatives' role as related to Medicaid "claiming practices," estimated expenditures, and backup documentation for expenditures claimed on the Medicaid expenditure report. NH Ex. 25, ¶ 6. Thus, CMS representatives' review of the documents New Hampshire provided could have been limited to determining whether the

[11] On appeal, New Hampshire indicates that the hospital-specific data used to calculate the payment adjustments were not exclusively drawn from comparable source documents. New Hampshire's Controller states in his declaration, "For **most** hospitals' [FFY] 2004 DSH calculations, the data supplied by the hospitals was from their hospital fiscal year 2002 audited financial statements." NH Ex. 25, at ¶ 4 (emphasis added). New Hampshire does not identify the sources of the data not drawn from audited financial statements.

DSH payment amounts that the hospitals received for a particular period were accurately reflected on the Medicaid expenditure reports submitted by New Hampshire or the supporting records. New Hampshire provided no evidence that it specifically asked the on-site representatives to review the formula or the related cost categories reflected on the forms it says it provided to the representatives, that the representatives, in fact, did such a review, or that the representatives (whom New Hampshire does not identify by name) had the authority to approve the methodology on behalf of CMS.

Without such evidence, we cannot find that New Hampshire reasonably thought it had implicit CMS approval for its UCC formula. Moreover, even though the documents provided to the CMS representatives evidence a formula that purports to use a ratio of costs to charges, the documents do not on their face show that New Hampshire was including non-patient care costs (such as advertising and gift shops) in the numerator. NH Exs. 8, 9. New Hampshire points out that the forms do mention bad debt, but they do not show bad debt as being included in line C, which is used as the numerator in calculating the "RCC (Ratio Cost/Charges)." *Id.* In addition, the documents do not define the terms used on the form, so it is not clear how the representatives would know that the net services revenue line was not equivalent to charges.

We additionally conclude that the "global agreement" reached by CMS and New Hampshire following the 2003-2004 negotiations over proposed SPAs and the MET did not constitute approval by CMS of the DSH payments at issue. NH Br. at 11. Contrary to New Hampshire's current characterization, the referenced SPAs simply did not address the methodology in dispute. Most notably, in transmittal 03-004, New Hampshire sought to increase the DSH payment limits for State-owned psychiatric facilities. CMS Exs. 21-23. The proposed SPA, New Hampshire explained at the time the original proposal was under review, did not address DSH payments for the general and rehabilitative hospitals at issue here. CMS Ex. 21, at 2. On review of the proposed SPA, CMS discovered that New Hampshire's six percent MET on general and rehabilitative hospitals was based on gross (as opposed to net) revenues, and therefore was impermissible under the Medicaid regulations governing health care-related taxes. CMS Br. at 14, *citing* CMS Ex. 21, at 2; CMS Ex. 24; 42 C.F.R. § 433.68(f) (3)(i) (2004). Following the parties' negotiations, New Hampshire agreed to seek a change in the state statute to convert the MET to a tax on net patient services revenue. CMS Ex. 24. CMS then approved a revised SPA that increased the DSH payment limit for the State psychiatric hospitals and provided that, effective "for services on or after July 1, 2005, the DSH payments to private hospitals [would] be based on their costs of providing uncompensated care to Medicaid and uninsured individuals," that is, without regard to the MET. CMS Ex. 22. While this meant that the MET would no longer act as a limit on DSH payments to general and rehabilitative hospitals, that determination was made because of concerns about the MET,

not because any other aspect of the methodology was at issue. The evidence is thus insufficient to establish that, by accepting the agreement, CMS was approving the cost-apportionment methodology on which New Hampshire relied to determine the DSH payment adjustments at issue. Accordingly, we conclude that the agreement does not preclude the disallowance here. Since we reject New Hampshire's factual assertions regarding CMS approval of the methodology at issue, we also reject New Hampshire's arguments premised on such approval.

3. We reject New Hampshire's argument that the disallowance should be reversed because it is inconsistent with prior CMS statements and actions.

Finally, New Hampshire contends that any mistakes it made in calculating UCC are "paradigmatic examples of the type of error for which CMS has previously said it would not impose retroactive disallowances." NH Br. at 28. New Hampshire argues that prior to the implementation of new DSH audit and reporting regulations, "CMS did not require states to recoup payments that exceeded the hospital-specific DSH limit due to disagreements about . . . the appropriateness of a State's formula for computing UCC." NH Reply at 14-15. New Hampshire contends that the rule "did not purport to be effective before January 19, 2009," and that CMS policy was that DSH payments exceeding "audit-determined UCC" would not be deemed overpayments for which the federal share must be returned until Medicaid State plan rate year 2011. NH Br. at 29-30, *citing* 73 Fed. Reg. at 77,904, 77,906 (Dec. 19, 2008). New Hampshire also relies on the following preamble language:

> [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 year 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.

Id. New Hampshire adds that subsequent CMS guidance confirmed that CMS would not require retroactive collection of DSH overpayments such as those at issue here. New Hampshire Br. at 30, *citing* "Additional Information on the DSH Reporting and Audit Requirements," at 6 (Jan. 2010)(NH Ex. 23).

We reject this argument. The statutory provision implemented in the DSH audit and reporting rule is section 1923(j) of the Act, which imposed new requirements for "independent certified audits" of DSH payments under state Medicaid programs, as provided under section 1001(d) of the 2003 MMA. 73 Fed. Reg. at 77,904; 42 C.F.R. Part 455. The preamble language quoted by New Hampshire does refer to "audits" and "audit methodologies," but does not mean the existing type of reviews or audits that the

OIG conducted to assess whether DSH payments were consistent with section 1923(g) of the Act. Rather, as the Board recently stated, "the context makes clear that the preamble means the new, 'independent certified audits' which the Final DSH Audit Rule requires be conducted using certain standards and definitions." *Louisiana Dept. of Health and Hospitals,* DAB No. 2350, at 17 (2010). The new regulations provided for a "transition period" for "Medicaid State Plan years 2005–2010" for "developing and refining [such] audit practices." 73 Fed. Reg. at 77,908; 42 C.F.R. § 455.304(e). CMS expressly stated in the preamble that "the regulatory transition provision is **not intended to preclude review of DSH payments and discovery of overpayments prior to Medicaid State plan rate year 2011, to the extent that such review is independent of the State audit process."** *Id.* (emphasis added). Therefore, we conclude that nothing in the final DSH audit rule or its preamble precludes the FY2004 disallowance here.

New Hampshire also contends that we should reverse the disallowance because CMS's decision to issue a disallowance in this case is inconsistent with CMS's actions in analogous matters. New Hampshire cites a March 2006 multi-state OIG audit report that concluded that DSH payments claimed by nine states exceeded the limits imposed under section 1923(g) and recommended that CMS "resolve[]" the excess payments. NH Ex. 17, App B at 2. CMS responded that it interpreted the OIG recommendation as "a prospective resolution and not a requirement to recoup Federal payments associated with the findings." *Id.* Though CMS ultimately imposed disallowances for DSH payments claimed by some of the states audited by the OIG, New Hampshire argues that those disallowances are distinguishable from this matter. NH Reply at 14-15.
We reject this argument. The Board previously has held that "allegations of disparate treatment, even if true, do not prohibit an agency of this Department from exercising its responsibility to enforce statutory requirements.'" *Municipality of Santa Isabel*, DAB No. 2230, at 12 (2009), quoting *National Behavioral Center, Inc.*, DAB No. 1760, at 4-5 (2001), and decisions cited therein.

In any event, New Hampshire's claim of disparate treatment is simply unfounded. The Board has previously reviewed multiple disallowances imposed by CMS based on the hospital-specific DSH limits established under section 1923(g). DAB No. 2161; DAB No. 2084; *New York State Department of Health*, DAB No. 2037 (2006); *Louisiana Dept. of Health and Hospitals*, DAB No. 1772 (2001). In addition, the record shows that CMS has imposed disallowances based on section 1923(g) in six other cases. CMS Exs. 36-41. Furthermore, of the 18 cases that were the subject of the March 2006 OIG consolidated report, CMS provided evidence that it has imposed disallowances in five cases; has obtained voluntary refunds of FFP in five cases; has "deleted the deficiency after working with the State to investigate and recalculate the data" in one case; and disagreed with the OIG's findings in two cases. CMS Br. at 37; CMS Ex. 42. CMS also provided evidence that it "decided to seek only prospective relief in one of the cases, which also involved a different issue than the present case . . . and three cases are still under review." CMS Br. at 37-38; CMS Ex. 42.

Thus, we conclude that CMS's decision to issue a disallowance in this matter is consistent with CMS policy and practice. Neither prior CMS statements nor CMS decisions not to impose disallowances in other matters provide a basis for reversing this disallowance.

Conclusion

For the reasons stated above, we uphold the disallowance.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member