

Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Arkansas Department of Health and Human Resources  
Docket No. A-06-73  
Decision No. 2201

DATE: September 30, 2008

DECISION

The Arkansas Department of Health and Human Services (Arkansas) appealed an April 7, 2006 decision by the Centers for Medicare & Medicaid Services (CMS) to disallow \$4,449,682 in federal reimbursement for Medicaid payments that Arkansas made to the University of Arkansas for Medical Sciences (UAMS) for outpatient hospital services in the five quarters from July 1, 2001 through September 30, 2002. UAMS is a state-operated teaching hospital. CMS issued the disallowance because it determined that Arkansas' Medicaid payments to UAMS in these five quarters exceeded what was permissible under Medicaid upper payment limit regulations that CMS promulgated in a January 12, 2001 Final Rule.<sup>1</sup> One of those regulations – 42 C.F.R. § 447.321(e)(2)(i) – is the asserted legal basis for the disallowance. The meaning and application of that regulation, which we call the "must not increase" provision, is the heart of the parties' dispute.

In Missouri Dept. of Social Services, DAB No. 2184 (2008), the Board held that the "must not increase" provision is ambiguous but that CMS had given the provision a reasonable interpretation. The Board also held that the state of Missouri failed to prove that it relied to its detriment on a reasonable alternative interpretation. For these reasons, the Board deferred to CMS's interpretation of the "must not increase" provision in that case.

Here, Arkansas contends, on various grounds, that CMS misinterpreted and misapplied the "must not increase" provision in disallowing federal reimbursement for its Medicaid payments to UAMS. As we discuss below, we reject Arkansas' arguments against

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<sup>1</sup> Final Rule, *Medicaid Program; Revision to Medicaid Upper Payment Limit Requirements for Hospital Services, Nursing Facility Services, Intermediate Care Facility Services for the Mentally Retarded, and Clinic Services*, 66 Fed. Reg. 3148 (Jan. 12, 2001).

CMS's interpretation and reaffirm that we find it reasonable. We also find insufficient evidence that, when it made the disputed Medicaid payments to UAMS, Arkansas relied on a different reasonable interpretation of the "must not increase" provision. CMS's calculations of the disallowance here do not, however, appear to track the methodology and interpretation that CMS itself set out. In addition, the record does not provide all the information needed to determine what amount, if any, should be disallowed under that interpretation. Accordingly, we remand this case to CMS for further action consistent with this decision.

### Legal Background

The Board's decision in Missouri contains a comprehensive discussion of the relevant legal background. DAB No. 2184, at 3-9.<sup>2</sup> The following is a condensed version of that discussion, which we incorporate by reference.

The federal Medicaid statute, title XIX of the Social Security (Act), authorizes a program that furnishes medical assistance to certain needy and disabled persons. Act § 1901. The program is jointly financed by the federal and state governments. Id. § 1903; 42 C.F.R. § 430.0. Each state administers its own Medicaid program pursuant to broad federal requirements and the terms of its "plan for medical assistance," which must be approved by CMS on behalf of the Secretary of Health and Human Services. Act § 1902; 42 C.F.R. §§ 430.10-430.16. Once its Medicaid plan is approved, a state becomes entitled to receive federal reimbursement, also known as "federal financial participation" (FFP), in payments it makes to health care providers for covered medical services furnished to Medicaid recipients. Act § 1903(a).

Medicaid program regulations provide that a state's Medicaid payments for certain inpatient and outpatient medical services may not, in the aggregate, exceed a "reasonable estimate" of what would have been paid for those services under Medicare payment principles. See, e.g., 42 C.F.R. §§ 447.272(b), 447.321(b). This reasonable estimate constitutes a ceiling called an upper payment limit (UPL). FFP is not available for state Medicaid expenditures that exceed an applicable UPL. Id. §§ 447.257, 447.304.

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<sup>2</sup> The Missouri decision is available to the public at <http://www.hhs.gov/dab/decisions/dab2184.pdf>.

Prior to March 13, 2001 – the effective date of the Final Rule – Medicaid program regulations imposed a single aggregate UPL for all Medicaid-covered “outpatient hospital services.” 42 C.F.R. § 447.321 (Oct. 1, 2000). In other words, total Medicaid payments by a state for outpatient hospital services provided by public and private facilities could not exceed a reasonable estimate of what the state would have paid in the aggregate for those services under Medicare payment principles. Id.

CMS issued the Final Rule because it was concerned that existing UPL regulations created an incentive for states to make excessive Medicaid payments to certain groups of facilities. See 66 Fed. Reg. at 3149-50. To counter that incentive, the Final Rule eliminated the aggregate UPL for all outpatient hospital services and established separate UPLs for each of the following groups of facilities: state government-owned or operated facilities, non-state government-owned or operated facilities, and privately owned and operated facilities.<sup>3</sup> Id. at 3150. These group-specific UPLs are codified in 42 C.F.R. § 447.321(a) and (b), which provide:

(a) *Scope.* This section applies to rates set by the agency to pay for outpatient services furnished by hospitals and clinics within one of the following categories:

(1) State government-owned or operated facilities (that is, all facilities that are either owned or operated by the State).

(2) Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State).

(3) Privately-owned and operated facilities.

(b) *General rule.* Except as provided for in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles . . . .

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<sup>3</sup> Similar changes were made to the UPL regulations applicable to Medicaid payments for inpatient hospital, nursing facility, and other services. See 66 Fed. Reg. at 3148, 3150.

Recognizing that immediate compliance with the new group-specific UPLs might significantly disrupt state budgets, CMS established "transition periods" beginning on March 13, 2001 in which eligible states could, with certain limitations, continue to exceed the new UPLs before having to achieve full compliance. See DAB No. 2184, at 4-5. In order to have qualified for a transition period, a state needed to have had in place, prior to March 13, 2001, an approved state plan payment provision that resulted in Medicaid payments which exceeded one or more of the new group-specific UPLs. Id. at 29. The length of a state's transition period depended upon how long its "noncompliant" payment provision was in place prior to March 13, 2001. Id. at 1.

The Final Rule established three transition periods, which we refer to as the short, three-year, and five-year transition periods. 42 C.F.R. § 447.321(e)(1)(i), (e)(2)(ii) (Oct. 1, 2001). Under the three- and five-year transition periods, which applied to states with noncompliant payment provisions that went into effect between October 1, 1992 and October 1, 1999 or prior to October 1, 1992 respectively, states were obligated to incrementally reduce or phase-out what the Final Rule's preamble calls "excess" or "excessive" payments. Id. § 447.321(e)(2)(B), (C); see also 66 Fed. Reg. 3162.<sup>4</sup>

The Medicaid payments at issue here were made pursuant to an Arkansas state plan provision that became effective on or after October 1, 1999. States with approved provisions that were effective after October 1, 1999 and approved before January 22, 2001 were eligible only for the short transition period established by 42 C.F.R. § 447.321(e)(2)(ii)(A), which states:

For State plan provisions that are effective after September 30, 1999 and were approved before January 22, 2001, payments may exceed the *upper payment limit in paragraph (b)* of this section until September 30, 2002.

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<sup>4</sup> The regulations denote the excess payments that must be reduced during the three- and five-year transition periods with the algebraic term "X," which is defined as the difference between the Medicaid payments made to a group of facilities (e.g., state government-owned or operated facilities) in state fiscal year 2000 and the amount of Medicaid payments that could have been made to that group of facilities in state fiscal year 2000 had the UPL for that group applied during that fiscal year. 42 C.F.R. § 447.321(e)(1)(iii); see also DAB No. 2184, at 14-15.

(italics added).<sup>5</sup> The "upper payment limit in paragraph (b)" is the requirement in section 447.321(b) that "aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) [i.e., state government-owned or operated, non-state government-owned or operated, or privately-owned and operated] may not exceed a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles[.]" Unlike the three- and five-year transition periods, the short transition period had no schedule for reducing or phasing out X (excess payments during the state fiscal year (SFY) 2000 base period).

Included in the "general rules" for all transition periods is the "must not increase" provision, which states:

The amount that a State's payment exceeded the upper payment limit described in paragraph (b) of this section must not increase.

42 C.F.R. § 447.321(e)(2)(i).

#### Case Background

On November 29, 2000, CMS approved Arkansas state plan amendment (SPA) 00-10. Ark. Ex. 3. SPA 00-10 provided that, effective for cost reporting periods ending June 30, 2000, outpatient hospital services provided at Arkansas state-operated teaching hospitals were to be reimbursed "based on reasonable costs[.]" *Id.* SPA 00-10 further provided that, effective May 18, 2000, state-operated teaching hospitals qualified for an annual supplemental Medicaid payment – that is, a Medicaid payment in addition to the "reasonable cost" reimbursement it received for its Medicaid-covered outpatient hospital services. *Id.* SPA 00-10 called this supplemental payment an "outpatient reimbursement adjustment."

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<sup>5</sup> As promulgated in the Final Rule, the regulation establishing the short transition period stated:

For approved plan provisions that are effective on or after October 1, 1999, payments may exceed the limit in paragraph (b) of this section until September 30, 2002.

42 C.F.R. § 447.321(e)(2)(ii)(A) (Oct. 1, 2001). In September 2001, CMS amended that provision to reflect the creation of a special transition period for certain state plan amendments that were submitted to CMS before March 13, 2001 but approved on or after January 22, 2001. 66 Fed. Reg. 46,397 (Sept. 5, 2001).

Id. During the period relevant to this dispute, UAMS was the only state-operated teaching hospital in Arkansas. Ark. Br. at 1.

According to SPA 00-10, the annual outpatient reimbursement adjustment was to be determined by (1) *calculating* the "Medicare-related upper payment limit (UPL)" for all hospital outpatient services provided in the state and all services furnished by "non-hospital providers" that "could . . . have been provided through hospital outpatient departments," (2) *then subtracting* total Medicaid reimbursement for those services. Ark Ex. 3. The "UPL" identified in this formula is an aggregate limit applicable to payments to all types of facilities (public and private).<sup>6</sup> SPA 00-10 stated that the UPL – the "reasonable estimate" of what Medicare would have paid – would be determined by dividing total Medicaid payments included in the adjustment calculation by 80 percent (or 0.8).

In each quarter between April 1, 2000 and September 30, 2002, a period that included the short transition period established by the Final Rule, Arkansas made a supplemental Medicaid payment to UAMS pursuant to SPA 00-10. Each such payment was equal to one-quarter of the outpatient reimbursement adjustment for the state fiscal year (SFY) in question.<sup>7</sup> (Arkansas refers to these quarterly supplemental payments as "UPL payments.")

On April 7, 2006, CMS issued a notice of disallowance for \$4,449,682 in FFP. Ark. Ex. 1. The disallowance concerned Arkansas' supplemental Medicaid payments to UAMS in the five quarters from July 1, 2001 through September 30, 2002 (all within Arkansas' short transition period). According to the notice of disallowance, the amount disallowed was the federal government's

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<sup>6</sup> SPA 00-10 states that the outpatient reimbursement adjustment "will be calculated and based on the previous [state fiscal year's] outpatient Medicare-related upper payment limit (UPL) for as identified Medicaid reimbursed outpatient services and will be determined *from all (not just the Arkansas State Operated Teaching Hospital's) hospital outpatient departments' and non-hospital providers' reimbursed services.*" Ark. Ex. 3 (italics added).

<sup>7</sup> The outpatient reimbursement adjustment was \$56,520,972 in SFY 2001 (or \$14,130,243 per quarter), \$58,556,099 in SFY 2002 (or \$14,639,025 per quarter), and \$72,872,477 in SFY 2003 (or \$18,218,119 per quarter. Ark. Ex. 3.

share of supplemental payments to UAMS that exceeded the limit established by 42 C.F.R. § 447.321(e)(2)(i), the "must not increase" provision, during the short transition period.

Arkansas then filed this appeal. Between May and August 2006, the parties completed a round of briefing.<sup>8</sup> The Board then stayed its consideration of this case pending completion of the proceedings in Missouri. On July 11, 2008, the Board issued its decision in Missouri. In that decision, the Board upheld CMS's reliance on the "must not increase" provision to disallow federal reimbursement for Medicaid payments by the state of Missouri to non-state government-owned or operated nursing facilities.<sup>9</sup> The Board determined that the "must not increase" provision is ambiguous but held that CMS reasonably interpreted the provision as imposing the following limitation on states (like Missouri) with short transition periods: the amount by which a state's transition-period payments to a group of facilities (e.g., non-State government owned or operated facilities) exceeded the UPL for that group could be no greater than the amount by which Medicaid payments to that group exceeded that group's UPL in some comparable period prior to March 13, 2001, had that UPL been applicable to those payments prior to March 13, 2001. See DAB No. 2184, at 2, 19-20. Although Missouri did not have actual and timely notice of CMS's interpretation of the "must not increase" provision, the Board deferred to, and permitted CMS to apply, its interpretation because Missouri failed to show that it relied to its detriment on a reasonable alternative interpretation. Id. at 27-35, 37.

After issuing the Missouri decision, the Board invited Arkansas and CMS to submit written comments on the decision's effect in the present case and to address specifically (1) whether Arkansas formed and relied to its detriment on a specific reasonable alternative interpretation of the "must not increase" provision;

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<sup>8</sup> Arkansas filed its initial Brief in Opposition to Disallowance ("Ark. Br.") on May 31, 2006. On July 14, 2006, CMS filed a Respondent's Brief in Support of Disallowance ("CMS Response Br."). Arkansas filed a reply brief ("Ark. Reply Br.") on August 4, 2006.

<sup>9</sup> Missouri dealt with the "must not increase" provision in 42 C.F.R. § 447.272, which established UPLs for various "inpatient services," including nursing facility services. The "must not increase" provisions in sections 447.272 and 447.321 are identical.

and (2) whether the Board should sustain CMS's application of that provision to the transition-period payments to UAMS. In response to the Board's invitation, Arkansas and CMS submitted supplemental briefs.<sup>10</sup>

### Analysis

As discussed, the disallowance here is based on CMS's finding that Arkansas' supplemental Medicaid payments to UAMS during the short transition period (March 13, 2001 to September 30, 2002) violated the "must not increase" provision. In response, Arkansas makes the following broad contentions. First, it contends that CMS's interpretation of the "must not increase" provision is erroneous or unreasonable, and that the disallowance is based on that erroneous or unreasonable interpretation. Ark. Br. at 5-7; Ark. Supp. Br. at 6-9. Second, Arkansas contends that it made the disputed payments in reliance on its own reasonable alternative interpretation of the "must not increase" provision, and that those payments were fully consistent with that interpretation. Ark. Supp. Br. at 9, 12. Third, Arkansas contends that even if we defer to CMS's interpretation, the disallowance should be overturned because it is inconsistent with that interpretation. Id. at 4.

We address these arguments in the following four sections. In section one, we reject Arkansas' various arguments regarding the "must not increase" provision's meaning. Missouri held that CMS's interpretation of that provision is reasonable, and we reaffirm that holding. In sections two and three, we find that Arkansas did not have timely and adequate notice of CMS's interpretation of the "must not increase" provision but that Arkansas failed to prove that it relied to its detriment on a reasonable alternative interpretation. In section four, however, we conclude that the disallowance as calculated does not reflect CMS's interpretation of the "must not increase" provision.

1. *CMS's interpretation of the "must not increase" provision is reasonable.*

In its initial brief, Arkansas contends that the "must not increase" provision is applicable only to states with three- and five-year transition periods, not to states with short transition periods. Ark. Br. at 6-7. Arkansas finds support for this contention in the regulations establishing the three- and five-

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<sup>10</sup> Arkansas filed its supplemental brief on August 12, 2008 ("Ark. Supp. Br."), CMS on August 28, 2008 ("CMS Supp. Br.).



year transition periods. The phase-down or reduction schedules established for these transition periods obligates (or obligated) states to gradually reduce the amount of excess payments (or "X") that were being made pursuant to noncompliant state plan payment provisions in effect when the Final Rule was issued. 42 C.F.R. § 447.321(e)(2)(ii)(B), (C). The regulations specify a baseline period – SFY 2000 – for determining the amount of excess payments that must be reduced during these longer transition periods. Id. § 447.321(e)(1)(iii). Arkansas points out that, unlike the three- and five-year transition periods, the short transition period has no schedule for phasing out excess payments and "thus create[d] no occasion to apply 'X.'" Ark. Br. at 6. Arkansas asserts that if CMS had wanted to use X as a baseline for limiting Medicaid payments during the short transition period, it would have been a "simple matter" to make that clear in the "must not increase" provision's text. Id. at 7. Arkansas suggests that CMS's failure to specify a baseline period or reduction schedule for the short transition period means that there was no payment limitation applicable to that period, and that states could – without limit – exceed the new UPLs until September 30, 2002.

In Missouri, the Board held that CMS's interpretation of the "must not increase" provision as applying to all transition periods, including the short transition period, is reasonable. That decision explained:

"Transition period" is defined in the Final Rule as "the period of time beginning March 13, 2001 through the end of one of the schedules permitted under paragraph (e)(2)(ii) of this section." 42 C.F.R. § 447.272(e)(1)(i). One of those schedules is the transition period from March 13, 2001 through September 30, 2002 for post-1999 states set out at section 447.272(e)(2)(ii)(A). For the other states, the period before their phase-down schedules begin is also, by definition, included as part of their transition periods. Since the "must not increase" provision is couched as a general rule for transition periods, it is reasonable for CMS to interpret it to give effect to the provision in a way that affects all transition periods (not merely the phase-down periods).

DAB No. 2184, at 20. Nothing in Arkansas' argument persuades us that CMS's view is unreasonable. Contrary to what Arkansas suggests, CMS could not have simply referred to the "X" amount in the "must not increase" provision since states with a short transition period (those with state plans effective *after*

September 30, 1999) may not have been making supplemental payments through SFY 2000 – the base period for calculating “X.” Furthermore, as noted in Missouri, the fact that the “must not increase” provision does not specify a baseline period from which to measure “increases” in “excess payments” for states with a short transition period does not render CMS’s interpretation unreasonable given the discretion that states have to develop Medicaid payment methodologies:

The Medicaid program generally permits considerable discretion by the individual states in developing payment methodologies so long as they are approved by CMS and conform to applicable statutory and regulatory requirements. Hence, CMS could reasonably interpret the “must not increase” provision to allow states to develop differing methodologies to determine the amount of their caps so long as those methodologies were consistent with the “must not increase” provision. While we have noted that this understanding of the determination of the cap as within the states’ discretion is not self-evident from the regulatory language, Missouri has shown, and we find, no basis to consider it unreasonable.

DAB No. 2184, at 20.

Next, Arkansas contends that CMS’s interpretation of the “must not increase” provision is unreasonable because states with short transition periods had no opportunity to make necessary budget changes. Ark. Br. at 7-8; Ark. Supp. Br. at 9. According to Arkansas, this reading would defeat the purpose of the transition period, which was to make immediate budget changes unnecessary. Id. We find no merit to this contention. In Missouri, the Board noted that the transition periods were intended to permit a reasonable period for budget action to make states fully compliant with the new *UPLs*. DAB No. 2184, at 34. The limit specified by the “must not increase” provision is *not* one of the new *UPLs*, however. The Board in Missouri also determined, moreover, that the transition periods were not intended to protect existing state Medicaid financing arrangements *at any cost*:

[W]hile we are not without sympathy for the practical difficulties presented to states by the changes in permissible financing methodologies, the preamble actually states that the transition periods themselves were provided in order to balance the “need to protect the fiscal integrity of the Medicaid program with State

budget issues." 66 Fed. Reg. at 3161 (Emphasis added.). We cannot conclude that it was inconsistent with this balancing effort to cap further increases in "excess payments" during the short transition period before full compliance.

Id. Finally, the Board went on to state that "[w]hile placing a cap on increases [in excess payments] otherwise allowed under existing state plans may well affect budget planning, it does not impose an actual reduction in funding which the state had been receiving, as did the new UPL limits with which states had to comply after their transition periods." Id. at 35. In short, we find nothing in the Final Rule which immunized states from the budgetary impact of the "must not increase" provision.

Finally, Arkansas suggests that CMS's "interpretation as applied to Arkansas" is unreasonable. Ark. Supp. Br. at 8, 9-10. Arkansas asserts that payments to UAMS increased during the transition period solely because of increases in "utilization" (the quantity of Medicaid-covered services paid for in a given period). Id. at 11. According to Arkansas, CMS's interpretation of the "must not increase" provision effectively freezes "aggregate UPL payments" as of March 13, 2001 "without any allowance for increases in utilization[.]" Id. at 9. Arkansas asserts that there is nothing in the January 12, 2001 Final Rule or its preamble which suggests that states had to freeze their supplemental Medicaid payments during a transition period despite increases in Medicaid utilization.<sup>11</sup> Id. at 8-9.

This element of Arkansas' argument mainly addresses not the regulatory interpretation put forward by CMS but rather the calculation methodology that CMS apparently used to determine the disallowance amount here. CMS's interpretation of the "must not increase" provision, which we have upheld, requires that the total supplemental Medicaid payments made for some base period to a group of facilities prior to March 13, 2001 under the then-applicable UPL ceiling be compared to the amount of supplemental

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<sup>11</sup> When it uses the term "UPL payment," Arkansas is referring to the quarterly supplemental Medicaid payments to UAMS that constitute UAMS's annual "outpatient reimbursement adjustment." Assuming that Arkansas applied the formula in SPA 00-10 for calculating the outpatient reimbursement adjustment, Arkansas' UPL payments during the short transition period were equal to the amount by which the UPL for all Medicaid-covered outpatient hospital services in Missouri during that period exceeded actual Medicaid payments for those services.

payments which would have been permissible if the new UPL for those facilities had then been in effect. CMS calls the difference the "excess payment" amount. That excess payment amount is then to be added to the amount that would be permissible under the new UPL ceiling during the transition period to limit payments under the "must not increase" provision. An increase in service utilization would increase the amount of the reasonable estimate of what Medicare would pay for those services and therefore the amount of the new UPL, but would not increase the permissible excess payment amount.

As we discuss below, CMS confused the situation in the present case by apparently simply adopting the amount of the actual outpatient reimbursement adjustments (or UPL payments) made by Arkansas in SFY 2001 as a cap on such payments during Arkansas' short transition period. CMS neither offers an explanation for its use of this approach here nor claims that it acted on an interpretation different from the one it has articulated both in this case and in Missouri. We discuss the calculation of the disallowance in section four, but for purposes of this section we simply conclude that Arkansas' arguments about the errors in applying CMS's interpretation do not require us to reevaluate our conclusion that the CMS interpretation is reasonable and permissible.

In sum, for the reasons above, we reaffirm the Board's holding in Missouri that CMS has given the "must not increase" provision a reasonable interpretation.

2. *Arkansas did not have actual and timely notice of CMS's interpretation of the "must not increase" provision prior to making its supplemental payments to UAMS during the short transition period.*

In general, we defer to CMS's reasonable interpretation of an ambiguous Medicaid regulation so long as the state had adequate notice of that interpretation. DAB No. 2184, at 2. Even if such notice was not given or received, we defer to CMS's reasonable interpretation unless the state proves that it relied to its detriment on a reasonable alternative interpretation. Id. at 2, 35.

Having found CMS's interpretation of the "must not increase" provision to be reasonable, we consider whether CMS provided Arkansas with adequate notice of that interpretation. In Missouri, the Board held that the preamble to the Final Rule did not provide adequate notice of CMS's interpretation of the

provision as it applied to states with short transition periods. DAB No. 2184, at 21-26. That holding applies equally to Arkansas. In addition, the record here contains no evidence that, at any time prior to the end of the short transition period, CMS notified Arkansas of its interpretation of the "must not increase" provision via program instructions, policy letters, or other formal or informal contacts with agency officials. Accordingly, we consider next whether Arkansas formed and relied to its detriment on a specific reasonable alternative interpretation.<sup>12</sup>

3. *Arkansas has not proven that it actually formed and relied to its detriment on a specific reasonable alternative interpretation.*

According to Arkansas, the "must not increase" provision permitted increases in payments to UAMS as long as those increases did not result from state action to increase the relevant Medicaid payment "rate" – the per-unit payment for a particular Medicaid-covered service – or from changes to the relevant Medicaid payment methodology. Ark. Supp. Br. at 4-5, 7-8, 10. In support of that proposition, Arkansas points out that the "must not increase" provision uses the term "payment" in the singular, i.e., "[t]he amount that a State's *payment* exceeded the

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<sup>12</sup> Relying on Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1 (1981), Arkansas suggests that the disallowance should be overturned "unless the ["must not increase" provision] is found to have put the State on clear notice that maintaining its methodology would result in a disallowance." Ark. Supp. Br. at 3 n.4. In Pennhurst, the Supreme Court held that "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." 451 U.S. at 17. We find little merit in Arkansas' Pennhurst contention in part because the "must not increase" provision's text made it clear that CMS had imposed *some* limitation on transition-period payments. Although the "must not increase" provision did not specify a method for determining that limitation, the Board emphasized in Missouri that CMS permitted states with short transition periods "to devise their own method of calculating excess payment levels so long as they were reasonable and consistent with the policy CMS was seeking to enforce." DAB No. 2184, at 21-22. The Board also found that it was incumbent on the state to consult with or seek guidance from CMS as to any apparent ambiguity. For these reasons, we conclude, as in Missouri, that the "must not increase" provision did not implicate the concerns in Pennhurst (and other cases). Id. at 37 n.21.

upper payment limit . . . must not increase" (italics added). In contrast, says Arkansas, section 447.321(b)(2) states that "aggregate Medicaid payments to a group of facilities . . . may not exceed the upper payment limit" (italics added). *Id.* at 7, 10. Based on this putative distinction between "payment" and "payments," Arkansas' interpretation is that the "must not increase" provision merely forbade it from (1) increasing the per-service payment rate for Medicaid-covered outpatient hospital services, or (2) altering its method of determining the UPL embedded in SPA 00-10's formula for calculating the outpatient reimbursement adjustment. *Id.* at 9-10. Arkansas contends that it acted consistently with this interpretation by continuing to use, throughout the transition period, the formula in SPA 00-10 for calculating the outpatient reimbursement adjustment and by not altering the numerical factor (0.8) embedded in that formula. *Id.* at 4-5, 10. Arkansas maintains that it "reasonably believed that by maintaining its UPL payment structure, it was faithfully ensuring that any amounts in excess of the new UPL were not increasing." *Id.* at 9.

We find no merit to this argument. First, there is insufficient evidence that Arkansas actually formed an interpretation of the "must not increase" provision by the time it made the disallowed payments to UAMS. Arkansas' claim of reliance on some alternative interpretation is based on nothing more than inaction, i.e., that it made no changes to its UPL payment methodology during the transition period. That same fact supports, in equal measure, a finding that Arkansas ignored or overlooked the "must not increase" provision in going forward with its payments to UAMS during that period.<sup>13</sup>

In any event, Arkansas' interpretation of the "must not increase" provision is not reasonable. In essence, Arkansas contends that the "must not increase" provision should be read as simply a prohibition on payment "rate" increases or changes to existing payment methodologies. We see little, if anything, in the provision's text which supports that view, however. The provision does not contain the term "rate," nor does it imply that states will be deemed in compliance by leaving existing payment "methods" intact. Moreover, the "must not increase" provision expressly refers to section 447.321(b) as the benchmark for its "payment" limitation. That paragraph contains the group-specific UPLs, which are limitations on aggregate payments, not payment rates. In addition, the Final Rule's preamble makes it

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<sup>13</sup> There is no evidence in the record that Arkansas sought guidance from CMS as to the provision's meaning or applicability.

clear that CMS intended the "must not increase" provision to impose *some* limitation on payments that exceed the new UPLs. 66 Fed. Reg. 3163 (noting that while CMS "included generous transition periods," it did not think it "appropriate to permit States to make *payments that would further increase the amount of payment that is in excess of the new UPLs*" (italics added)).

In support of its belief that keeping its "UPL payment" methodology constant was sufficient to comply with the "must not increase" provision, Arkansas points to the following sentence from the preamble to the Final Rule: "The amount of spending permitted under the [upper payment] limits will vary directly with the amount of Medicaid services furnished by public facilities to eligible individuals." Ark. Supp. Br. at 11 (citing 66 Fed. Reg. 3173). Arkansas says that this sentence reflected CMS's awareness or expectation that changes in "utilization" would cause "UPL spending" to go up or down but not alter the "UPL gap" or cause a state to run afoul of the "must not increase" provision. *Id.*

The sentence which Arkansas quotes does not help its position. The following is the preamble passage in which that sentence appears:

It is important to note that, although it will reduce FFP on excess enhanced payments as estimated above, this regulation does not reduce the overall aggregate amount States can spend on Medicaid services or place a fixed ceiling on the amount of State spending that will be eligible for Federal matching dollars. Under the limitations in this final rule, States will be able to set reasonable rates as determined under Medicare payment principles for Medicaid services furnished by public facilities to eligible individuals. *The amount of spending permitted under the limits will vary directly with the amount of Medicaid services furnished by public facilities to eligible individuals.* While this final rule does not affect the overall aggregate amount States can spend, by setting an upper payment limit for government facilities, it may impact how States distribute available funding to participating health care facilities.

66 Fed. Reg. 3173 (italics added). We see nothing in this passage which might reasonably have caused Arkansas to believe that it could comply with the "must not increase" provision without regard to the amount of payments it made so long as it left intact its payment rates or methodologies. The sentence

quoted by Arkansas merely indicates that when a state makes Medicaid payments for services provided by a group of facilities up to "reasonable rates as determined under Medicare payment principles," then increases in the quantity of services provided by that group will result in an increase in the corresponding UPL for that group. Total Medicaid spending permitted *under the UPL* will increase, but the issue here is whether the amount in excess of that UPL may increase. The preamble does not discuss what amount of payment beyond the new UPL would be permitted by the "must not increase" provision during the short transition period.

Arkansas asserts that it did not "consider the possibility that it had to submit a State Plan Amendment to lower its payment methodology, particularly in light of the requirement in [section 1904 of the Act] that states follow their approved state plans." That failure is not a basis for reversing the disallowance. Although states must follow their plans, longstanding regulations provide that plans must comply – and if necessary be amended to comply – with federal law. 42 C.F.R. § 447.302; see also 42 C.F.R. § 430.12(c)(1) (State plans must be amended to reflect changes in federal law and regulations). As indicated in Missouri, it would have been unreasonable for a state *not* to consider the potential necessity of amending its state plan or taking other steps necessary to bring it into compliance with the "must not increase" provision. DAB No. 2134, at 34 ("[w]hile states are indeed required to make Medicaid payments using the methodology in their approved state plans and not to make material changes without notice to providers, those requirements do not justify ignoring the restriction on increasing payments here.").

4. *CMS's method of determining whether Arkansas violated the "must not increase" provision is inconsistent with its interpretation of that provision.*

As we have explained, under CMS's interpretation of the "must not increase" provision, the amount of a state's pre-March 13, 2001 "excess payments" – that is, the amount by which a state's Medicaid payments to a group of facilities during a pre-March 13, 2001 baseline period exceeded the group's UPL for that period (had the group-specific UPL been in effect during the baseline period) – constitutes a cap or ceiling on the amount of excess payments that the state may make to the same group of facilities



during the transition period.<sup>14</sup> Thus, under CMS's interpretation, in order to determine whether Arkansas violated the "must not increase" provision, CMS or the state must first select an appropriate pre-March 13, 2001 baseline period and then determine the amount by which Medicaid payments to the relevant group of facilities (here, state government-owned or operated facilities) during that baseline period exceeded the separate UPL for that group (had it applied during the baseline period).<sup>15</sup> Next, for any portion of the transition period that is comparable to the chosen baseline period, CMS or the state must determine the amount by which Medicaid payments *during that portion of the transition period* exceeded the group's UPL for that period. If a state's excess payments during that part of the transition period are greater than the excess payments made in the comparable baseline period, then CMS may disallow the difference under the "must not increase" provision.

In its April 7, 2006 notice of disallowance, CMS claimed to have identified the "limit specified" by the "must not increase" provision. Ark. Ex. 1, at 2. CMS stated that this limit was "the extent to which the State's payments [to UAMS] for the

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<sup>14</sup> In draft guidance that was circulated informally among some states, CMS provided the following example of what it thought was an acceptable approach to calculating the payment limit mandated by the "must not increase" provision:

"NF [nursing facility] UPL for local government facilities in the first quarter of 2001 is \$80.

"The state paid \$180 to local government providers [in the first quarter of 2001].

"\$100 is the amount above the UPL.

"This \$100, sometimes referred to as the excessive payment amount, cannot be increased although the UPL itself may go up due to changes in Medicare payment systems . . . ."

DAB No. 2184, at 37-38 (quoting CMS's draft guidance).

<sup>15</sup> CMS has acknowledged that the "must not increase" provision does not identify a baseline period from which no increases in the excess payments can occur, so states have flexibility to choose an appropriate baseline period. DAB No. 2184, at 17.

quarter ending March 31, 2001 exceeded a reasonable estimate of the amount that would have been paid for the services furnished under Medicare payment principles[.]” Id. CMS then stated that it applied this limit “to calculate the extent to which payments in successive quarters until September 30, 2002 [the end of the transition period] exceeded this payment limit.” Id.

At face value, these assertions indicate that CMS used a methodology for verifying compliance with the “must not increase” provision that was consistent with its interpretation of that provision. However, closer scrutiny of the record suggests that CMS’s actual methodology was, in fact, inconsistent with its interpretation.

In further explaining the disallowance, the April 7 notice states that CMS calculated a “quarterly UPL payment cap” of \$14,639,025, which it deemed to be the limit specified by the “must not increase” provision. Ark. Ex. 1, at 2. The quarterly UPL payment cap is, however, simply equal to Arkansas’ quarterly UPL payment to UAMS for SFY 2001 (which is one quarter of UAMS’s annual outpatient reimbursement adjustment for SFY 2001).<sup>16</sup>

For each quarter of the short transition period, CMS determined whether Arkansas’ UPL payment in that quarter exceeded the quarterly UPL payment cap of \$14,639,023. If any portion of the quarterly UPL payments exceeded the quarterly UPL payment cap, the excess was found to violate the “must not increase” provision, and the federal share of that excess was disallowed.

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<sup>16</sup> According to the formula established by SPA 00-10, the outpatient reimbursement adjustment was equal to the amount by which the UPL (as estimated by Arkansas) for all Medicaid-covered outpatient hospital services furnished in Arkansas exceeded total Medicaid payments for those services. For SFY 2001, Arkansas calculated an outpatient reimbursement adjustment of \$56,520,972, then paid one-quarter of that amount – or \$14,130,243 – to UAMS in each quarter of SFY 2001. Ark. Ex. 2, at 1 (calculations under heading “SFY 2001 Outpatient Medicare Upper Limit Adjustment”); Ark. Ex. 1, at 2 (showing, in columns 1-3 of Table 1, that Arkansas claimed FFP for \$14,130,243 in “UPL payments” for each quarter of SFY 2001 (July 1, 2001 through June 30, 2002)). During SFY 2002, Arkansas’ quarterly “UPL payments” increased from \$14,130,243 to \$14,639,025. Id. at 3. For the first quarter of SFY 2003 (the last quarter of the short transition period), Arkansas’ UPL payment to UAMS was \$18,218,119. Id.

The following table summarizes how CMS calculated the disallowance:

(1)	(2)	(3)	(4)	(5)	(6)
Quarter Ending	Amount Claimed (UPL payment)	Amount Allowed (UPL Payment Cap)	Amount in Excess of UPL Payment Cap (column 2 minus column 3)	FMAP	Excess FMAP
9/30/00	14,130,243	\$14,130,243			
3/31/01	14,130,243	14,130,243			
6/30/01	14,130,243	14,130,243			
9/30/01	14,639,025	14,130,243	\$508,781	73.02	\$371,512
12/31/01	14,639,025	14,130,243	508,781	72.64	369,579
3/31/02	14,639,025	14,130,243	508,781	72.64	369,579
6/30/02	14,639,025	14,130,243	508,781	72.64	369,579
9/30/02	18,218,119	14,130,243	4,087,876	72.64	2,969,433
Total of FFP Disallowed (col. 6):					\$ 4,559,682

The problem with this set of calculations is that the quarterly UPL payment cap is *not* – or does not appear to be – the limit specified by the “must not increase” provision (as CMS has interpreted it). As explained, the quarterly UPL payment cap is the quarter-share of Arkansas’ SFY 2001 outpatient reimbursement adjustment, which, according to SPA 00-10, is equal to the gap between the UPL for outpatient hospital services provided by *all facilities* (public and private) and the amount of actual Medicaid payments for those services. That UPL gap described in SPA 00-10 does not figure at all into the calculation of the “must not increase” provision’s payment limit. The “must not increase” limit is the amount by which Medicaid payments to a *particular group of facilities* – the relevant group here being state government-owned or operated facilities – exceeded the *separate UPL for that group* during some pre-March 13, 2001 baseline period (had that separate UPL been applicable during the baseline period). There is nothing in the record which shows that CMS calculated that limit here. Consequently, we cannot determine based on the record how much, if any, of the amount at issue was properly disallowed.

Conclusion

We conclude that CMS articulated a reasonable interpretation of the "must not increase" provision and that Arkansas failed to show that it relied to its detriment on a reasonable alternative interpretation. However, the record fails to confirm that CMS actually applied its interpretation in calculating the disallowance amount. We therefore remand this case to CMS for further action consistent with this decision. On remand, CMS may issue a revised disallowance in conformance with its interpretation of the "must not increase" provision. Arkansas may return to the Board within 30 days of receiving CMS's revised disallowance if it disagrees with the calculation of the new amount.

\_\_\_\_\_/s/  
Judith A. Ballard

\_\_\_\_\_/s/  
Constance B. Tobias

\_\_\_\_\_/s/  
Leslie A. Sussan  
Presiding Board Member