Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Louisiana Department of Health and Hospitals
Docket No. A-10-11
Decision No. 2350
December 20, 2010

DECISION

The Louisiana Department of Health and Hospitals (Louisiana) appealed a disallowance by the Centers for Medicare & Medicaid Services (CMS) of $362,053,628 in federal financial participation (FFP) claimed by Louisiana under the Medicaid program. CMS found that Louisiana had claimed FFP for disproportionate share hospital (DSH) payments to State hospitals in excess of the hospitals' actual uncompensated care costs for State fiscal years 1996 through 2006 (SFY 96-06). During Board proceedings, the parties agreed to reduce the disallowed amount to $239,270,483.

This case raises two main issues: 1) whether Louisiana was required to adjust DSH payments it made based on estimates, so that the final payment amounts did not exceed each hospital's actual, audited uncompensated care costs; and 2) if so, whether any overpayments to the Medical Center of Louisiana at New Orleans (MCLNO) are "uncollectable" within the meaning of the Medicaid statute and regulations, so that Louisiana is not required to repay federal funds claimed for the overpayments.

For the reasons explained below, we sustain the disallowance. We conclude that the Louisiana Medicaid State plan required that DSH payments to a State hospital for any year not exceed the hospital's actual, audited uncompensated care costs for that year. Even if Louisiana had the flexibility to adopt a different payment methodology and did not intend to recover excess DSH payments directly from the State hospitals, Louisiana was required to follow its State plan methodology, once adopted, and to pay back the federal share of the resulting overpayments to the State hospitals, but did not do so. Further, the overpayments to MCLNO for SFYs 96-06 are not uncollectable within the meaning and purpose of the Medicaid statute and regulations. While MCLNO has much reduced its operations since 2005 as a result of Hurricane Katrina, MCLNO is neither bankrupt nor out of business.

Legal Background

Title XIX of the Social Security Act (Act) establishes the Medicaid program, authorizing federal grants to any state that has submitted, and had approved by the Secretary of Health and Human Services, a state plan for medical assistance.[1] CMS administers the Medicaid program on behalf of the Secretary. "Medical assistance" is defined in section 1905(a) of the Act and includes payment of part or all of the cost of "inpatient hospital services (other than services in an institution for mental diseases)." A state Medicaid plan must "provide such methods and procedures relating to the . . . payment for care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient" to ensure access to services. Act, § 1902(a)(30)(A).

A state plan must also provide for a public process for developing payment rates for hospital services under which, among other things, final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published. Act, § 1902(13)(A). Hospital rates must "take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate share of low-income patients with special needs; . . . ." *Id.* Such hospitals are referred to as "DSH" hospitals. Section 1923 of the Act was originally enacted to require states to amend their state plans to define DSH hospitals and "to provide for an appropriate increase in the rate or amount of payment" for hospital services, called a DSH "payment adjustment." Act, § 1923(a)(1). 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).

In 1993, Congress added section 1923(g) to the Act to provide for "hospital-specific" DSH limits. The House Budget Committee Report explained that the Committee was concerned by reports that some states had made DSH payment adjustments to state psychiatric or university hospitals in amounts that exceeded the net costs (and in some instances, the total costs) of operating the facilities and had transferred the excess to their general funds, using them for various purposes such as road construction and maintenance. H.R. Rep. No. 103-111, at 211-12 (1993), *reprinted in* 1993 U.S.C.C.A.N. 278, 578-79. Section 1923(g) provides, among other things, that the 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,

[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.

> 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.

These costs are referred to as uncompensated care costs (UCC).

In 2003, Congress enacted section 1923(j) of the Act, mandating improved accountability for DSH payments by providing that the Secretary of HHS require states to submit annual, independent certified audits of their DSH programs and annually report information on those programs. Final regulations implementing this provision were not published until December 19, 2008. 73 Fed. Reg. 77,904.

Section 1903 of the Act establishes what FFP is available to a state under Medicaid. FFP is available at the federal medical assistance percentage (FMAP) each quarter for "the total amount expended during such quarter as medical assistance under the State plan," subject to certain limits, including the state DSH allotment in section 1923(f). Act, § 1903(a)(1). Payments are made to states each quarter based on estimated expenditures for the quarter "reduced or increased to the extent of any overpayment or underpayment . . . for any prior quarter . . . ." Act, § 1903(d)(2)(A). Section 1903(d)(2)(C) provides that--

> when an overpayment is discovered which was made by a State to a person or other entity, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.

Subparagraph (D) provides:

> In any case where the State is unable to recover a debt which represents an overpayment . . . made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

We discuss the regulations implementing these provisions below.

Factual background

After Congress enacted the hospital-specific DSH limits in section 1923(g) of the Act, CMS conducted a review to ensure that Louisiana was in compliance with the new DSH provisions. For public hospitals in SFY 95 and for all hospitals in SFY 96, Louisiana required each hospital to submit an uncompensated care cost form after the end of the year. LA Ex. 8, at 1. Louisiana compared the amount reported on the form to the total

DSH payments for the year, and initiated steps to recover any overpayment if payments exceeded the limit, using the forms to comply with the limits until the hospital's cost report could be audited. *Id.* Thus, in 1997, CMS reported that Louisiana had "a method to initially detect overpayments within a reasonable period of time" and that, for "the majority of the overpayments detected, the State had already taken appropriate recovery action . . . and agreed immediately to take action on the remaining overpayments." *Id.* at 2.

In a letter dated October 24, 2002, however, CMS notified Louisiana that it had come to CMS's attention that "the federal share of some provider overpayments resulting from DSH payments in excess of the [hospital-specific limits was] not being refunded in a timely manner." CMS Ex. 3, at 1. An Office of the Inspector General (OIG) audit issued in June 2001 had recommended that the Louisiana State University (LSU) Health Care Services Division submit to Louisiana corrected UCC schedules incorporating audit adjustments totaling $22,184,812. *Id.* CMS's letter noted that, although the hospitals had submitted the corrected schedules to Louisiana in September 2001, the "overpayments were not set up as accounts receivables and the federal share has not been returned." *Id.* CMS requested return of the federal share on the next quarterly expenditure report.

In a letter to Louisiana dated December 2, 2002, CMS again addressed the issue of DSH payments. The letter noted that Louisiana had "apparently stopped adjusting [each] hospital's initial estimate of uncompensated costs, at least for the State-operated hospitals," after CMS had issued its 1997 report on Louisiana's compliance with the hospital-specific DSH limits, even though the State-operated hospitals had submitted UCC forms each year. CMS Ex. 4, at 2. This letter again stated that Louisiana should set up accounts receivables from hospitals that were overpaid and return the federal share within 60 days from discovery of the overpayments (which CMS said "occurs when the Medicaid agency receives an UCC form from a hospital that indicates the existence of a DSH overpayment"). *Id.*

The letter also enclosed, for each of the nine hospitals operated by the LSU Health Care Services Division, UCC schedules that were "provided by the Health Care Services Division and audited by the State legislative auditors." *Id.* The letter explained that the schedules cover "each State fiscal year from 1996 through 2002 and reflect DSH overpayments of $290,154,502 and DSH underpayments of $33,460,153 (as adjusted by legislative auditors)." *Id.* The letter noted, however, that the overpayment amount may reflect the "$22,184,812 for SFY 1998, which was returned on the Medicaid expenditure report for the quarter ended September 2002 as a result of OIG audit findings." *Id; see also* CMS Ex. 9 (schedules from the audited financial statements). CMS requested that Louisiana timely refund the federal share of the identified overpayments (or provide supporting documentation for any adjustments) and reinstate the procedures previously used or similar procedures to adjust the uncompensated cost estimates when actual cost data became available. *Id*.

On December 24, 2002, the Louisiana Medicaid Director wrote to the LSU Health Services Division asking it to provide any justifications that would "reduce or eliminate the overpayments," noting that Louisiana had 60 days from receipt of the notice of overpayment to return the federal funds. CMS Ex. 5. Louisiana subsequently requested that CMS reconsider its position regarding whether the costs of physicians and other practitioners could be included in calculating the hospital-specific DSH limits under section 1923(g) of the Act. CMS denied this request in a letter dated May 21, 2003. CMS Ex. 6.

In a letter to CMS dated October 21, 2003, Louisiana described its revised procedures for making DSH payments to the LSU Health Services Division, stating that these procedures "will prevent future overpayments." CMS Ex. 10, at 1. This letter also described audits of the outstanding cost reports. The letter informed CMS that the "audits tentatively show that from 1997 through 2002, DSH payments exceeded actual uncompensated costs by approximately $339 million in the aggregate ($240.2 million federal share)." *Id.* at 2. According to the letter, however, the audit settlements would "result in amounts payable to the hospitals for Medicaid (i.e., non-DSH) services in an aggregate amount equal to approximately $127 million ($89.6 million federal share), leaving a total aggregate payment in excess of actual costs equal to $212 million ($150.6 million federal share)." *Id.* at 2. Louisiana explained that the SFY 96 figures were excluded from this calculation because "in that year the total amount the State could draw as FFP was capped" and Louisiana had submitted claims for expenditures "well in excess" of the cap. *Id.* at 2 n.1.

In the October 2003 letter, Louisiana reasserted its position that the uncompensated costs of physicians and certified registered nurse anesthetists (CRNAs) who provided patient care to the uninsured should be used in calculating UCC for the hospitals. Louisiana proposed that CMS recognize these costs as allowable costs for DSH purposes, reduce the overpayment by the amount of such costs, and permit Louisiana to satisfy the remaining overpayment amount based on the "outstanding cost reports" for LSU Health Care Services Division. *Id.* at 4. This letter further stated that, for purposes of this proposal only, Louisiana "would accept the premise that the hospital-specific DSH limitations in Section 1923(g) [of the] statute requires a reconciliation to actual uncompensated costs," but that it did "not believe that such a reconciliation is required by **the statute or by agency policy**." *Id.* (emphasis added). This letter did not mention the methodology in the Louisiana Medicaid State plan for determining allowable DSH payments to the hospitals.

In April 2005, Louisiana again wrote to CMS about the matter, referring to the audit by the State legislative auditors that concluded that the nine LSU Health Care Services Division hospitals "had been overpaid because the estimates that [Louisiana] used to make the DSH payments . . . exceeded the hospitals' actual uncompensated costs during the seven years covered by the audit." CMS Ex. 11, at 1. This letter stated that, in a conference with the CMS regional office and a CMS official, the official had indicated a willingness to bring to CMS's leadership Louisiana's position that there should be no

disallowance with respect to these DSH payments. This letter referred back to the letter of October 2003, again explaining Louisiana's position regarding potential elimination of the remaining overpayment if the hospitals were permitted to include in UCC the costs they incur in paying physicians and CRNAs to provide care to the uninsured.

In 2006, the OIG issued an audit report summarizing its findings in audits of how states were applying the hospital-specific DSH limits, including its findings in the 2001 report on Louisiana. LA Ex. 12. In 2009, the United States Government Accountability Office issued a report to Congress about state DSH programs and CMS oversight of DSH payments. LA Ex. 17.

On September 15, 2009, CMS issued a determination disallowing $362,053,628 in FFP claimed by Louisiana. The disallowance letter referred to the UCC schedules for each of the nine State-operated hospitals under the LSU Health Care Services Division that were provided by that Division and audited by the State legislative auditors, as well as to additional documents provided by Louisiana in July 2008. The letter indicated that, based on CMS's review of the additional documents reflecting the results of some further cost report audits, CMS had determined that the DSH overpayments were actually $362,053,628. Disallowance ltr. at 2. This unrevised amount covers the period SFY 96 through SFY 06.[2]

Louisiana appealed. In its appeal brief, Louisiana argued that, assuming a disallowance were proper, CMS had overstated the amount. Louisiana's first ground for this assertion was that, during the later three quarters of SFY 96, Louisiana was authorized to use an alternative method for claiming FFP under which it was subject to a cap in exchange for receiving a higher FFP rate. Since Louisiana's documented expenditures for which it submitted Medicaid claims greatly exceeded the cap (and Louisiana covered the difference with State funds), Louisiana asserted that the expenditures for which it received no FFP should be substituted for any "disallowed DSH overpayments" as a basis for Louisiana's receipt of FFP. LA Br. at 20; LA Ex. 23 (Phillips Decl. ¶ 10). Louisiana's second ground for reducing the disallowed amount was that it should be offset by "the FFP corresponding to any amounts Louisiana distributes to correct for 'DSH underpayments.'" LA Br. at 20; LA Ex. 23 (Phillips Decl. ¶ 11).

In a declaration submitted with its response brief, CMS indicated that it would accept a modification based on the first ground, the alternative payment method issue, and that CMS had always considered it an option that Louisiana might make a further adjustment once it completed its assessment of DSH over/underpayment amounts. CMS Ex. 8 (Sampson Decl. ¶ 7). Louisiana subsequently requested that the Board remand the case

[2] For most of the years covered by the disallowance, the "actual" UCC shown on the additional documents submitted by Louisiana is based on the hospitals' audited cost reports. For more recent years, it is based on the hospitals' as-filed cost reports for the year in which the DSH payments were made because the DSH calculations from these periods had not been audited at the time of the disallowance. LA Ex. 23 (Phillips Decl. ¶ 5).

for determination of the amount prior to reaching the merits. CMS objected to a remand, asserting that the parties had agreed to modify the disallowance amount by making a downward adjustment of $76,195,065 for "SFY 96 Alternative Payment Method" and a downward adjustment of $18,758,064 for "DSH Over/Underpayments." CMS Reply Br. at 2. CMS identified the revised disallowance amount as $239,270,483. *Id.* Louisiana then agreed that $239,270,483 is the amount remaining in dispute. LA Rebuttal Br. at 1.[3]

Below, we address the arguments Louisiana makes with respect to the remaining disallowance.

Analysis

1. Even if Louisiana had the flexibility under section 1923(g) to determine hospital-specific DSH limits using estimated costs, FFP is available only for DSH payments that are determined according to the methodology that Louisiana adopted in its Medicaid State plan.

Much of Louisiana's argument on appeal goes to the issue of whether, during the disallowance period, Louisiana had the **flexibility** to determine the hospital-specific DSH limits for each hospital using estimated UCC, without subsequently adjusting the DSH payments based on actual UCC costs for the payment period. Louisiana argues that the statutory and regulatory DSH provisions did not limit DSH payments to actual UCC for the payment period until the later amendments to the statute and regulations that were not effective during the disallowance period. CMS's position is that, even if Louisiana could have chosen a methodology for determining DSH payments based on estimates, the statute and regulations make FFP available only in payments made according to the approved methodology in Louisiana's state plan.

We note that Louisiana's argument rests in part on a 1995 CMS issuance that stated it would be appropriate for a state to estimate the amount of **revenues** it expects to collect for uninsured services in calculating UCC, which is different from the issue of whether hospital-specific DSH limits could be based on estimated **costs**. LA Br. at 12, *citing* LA Ex. 4. We do not need to determine here, however, whether Congress intended when it first enacted section 1923(g) of Act to establish hospital-specific DSH limits based on actual UCC or to permit states to establish limits based on estimated costs. Even assuming states had the flexibility during the disallowance period to make final DSH payments based on estimated costs, once Louisiana nonetheless chose in its State Medicaid plan to base final payments on actual, audited UCC, Louisiana no longer had that flexibility.

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[3] Louisiana indicated that its calculation of the adjustments would result in a disallowance of $241,268,894, as reflected in its Exhibit 30. CMS did not, however, seek to make any further adjustments to the amount. Therefore, we accept the amount to which the parties agreed ($239,270,483) as the amount remaining in dispute.

As discussed above, FFP is available under the Act only in "medical assistance" under a state plan, and the state plan must set out the methodology to be used to reimburse hospitals for inpatient services, including how DSH payment adjustments will be determined. Medicaid regulations, moreover, require a state to "specify comprehensively in its state plan the methods and standards" used to set payment rates for inpatient hospital services in a manner consistent with the requirements for state plans. 42 C.F.R. §§ 430.10; 447.252; 447.201. FFP is available only in expenditures made in accordance with the approved state plan. 42 C.F.R. §§ 447.253(i), 447.257.

Based on such provisions in the statute and regulations, the Board has long held that states must follow the methods and standards set out in their approved state plans, and may not change their plan methodologies unilaterally. *Colorado Dept. of Health Care Policy and Financing*, DAB No. 2057 (2006); *New Hampshire Dept. of Health and Human Ser*vices, DAB No. 1862 (2003); *Louisiana Dept. of Health and Hospitals*, DAB No. 1542 (1995); *California Dept. of Health Services*, DAB No. 1474 (1994); *California Dept. of Health Services*, DAB No. 1007 (1989).

Thus, we conclude that FFP is available only for DSH payments that are determined according to the methodology that Louisiana adopted in its Medicaid State plan, even if Louisiana had the flexibility to determine hospital-specific DSH limits using estimates.

2. The plain language of the relevant Medicaid State plan provisions establishes that final, allowable DSH payments were to be determined using actual, audited UCC, not estimates.

Louisiana describes its State plan as calling for DSH payments based on the hospitals' best estimates of what their UCC would be for each year. LA Br. at 5. CMS argues that Louisiana's methodology for DSH payments during the disallowance period was not a "prospective" payment methodology allowing Louisiana to make final payments based on estimated costs. Instead, CMS argues, Louisiana's State plan adopted a "retrospective" methodology requiring that final DSH payment amounts be determined based on actual, audited UCC. Louisiana argues that CMS places too much weight on the use of the word "retrospective" in the State plan.

The Board generally defers to a state's reasonable interpretation of its own state plan. In *South Dakota Dept. of Social Services*, DAB No. 934 (1988), the Board stated:

> In considering whether a state has followed its approved state plan, the Board first examines the language itself. If the provision is ambiguous, the Board will consider whether the state's proposed interpretation gives reasonable effect to the language of the plan as a whole. The Board will also consider the intent of the provision. A state's interpretation cannot prevail unless it is reasonable in light of the purpose of the provision and program requirements. Lacking any documentary, contemporaneous evidence of intent, the Board may consider consistent administrative practice as evidence of intent. The importance of

> administrative practice is in part determining whether the state in fact was applying an official interpretation of a plan provision or has advanced an interpretation only as an after-the-fact attempt to justify acting inconsistently with or simply ignoring its plan.

DAB No. 934, at 4. The Board developed this approach for circumstances in which a state has flexibility in what state plan provisions to adopt, particularly with respect to reimbursement methodologies. As the quoted language makes clear, however, the Board considers a state's interpretation only when the words of the plan as a whole are subject to more than possible interpretation, that is, when the plan is ambiguous. As discussed above, moreover, states must follow the reimbursement methods and standards set out in their approved state plans, and may not change their plan methodologies without CMS approval.

Here, we conclude that Louisiana's reliance on language in the approved State plan permitting DSH payments based on estimates of UCC is misplaced. The key issue is whether those estimates established the final amount allowable under the State plan or whether the plan required that later adjustments be made based on the actual, audited UCC for the payment period. To resolve this issue and to understand the significance of the State plan language Louisiana adopted, it is necessary to understand the differences between a "retrospective" and a "prospective" reimbursement system.

Board decisions have long recognized that the term "retrospective" in the context of a Medicaid reimbursement methodology is a term of art derived from the Medicare program. For example, in *Arkansas Dept. of Human Services*, DAB No. 357 (1982) and *Illinois Dept. of Public Aid*, DAB No. 467 (1983), the Board cited a 1976 regulatory preamble discussion at 41 Fed. Reg. 27,300, 27,302 and described the differences between a retrospective and a prospective reimbursement system. In a "retrospective" system, a state makes payments to a provider such as a hospital during a rate period (usually a fiscal or calendar year) based on an "interim" rate. The interim rate is based on an estimate of the costs of providing the services (usually historical costs adjusted for expected inflation). At the end of the rate period, the provider submits a cost report of the actual costs incurred during that period. The cost report is subject to review and audit (and potentially a provider appeal). During this cost settlement process, interim payments are reconciled to actual costs and final payment is made. In contrast, payments made as part of a "prospective" reimbursement system are not adjusted based on actual costs incurred during the period in which the services were provided. *See also* 46 Fed. Reg. 47,964 (Sept. 30, 1981) (discussing historical reimbursement methods ranging from "the retrospective, reasonable cost reimbursement system" then used by Medicare to "prospective rates" based on state budgets and other factors).

Here, each Louisiana State plan amendment (SPA) on which Louisiana relies clearly provides for a retrospective DSH payment methodology for State-owned or -operated hospitals. LA Exs. 5, 7. Both SPA 95-30 and SPA 97-04 provide for partial "interim payments" for a payment period (SFY) running from October 1 to September 30 of a year

based on cost reports received or filed as of June 1 and for "[f]inal payment" that is "based on the uncompensated cost data per the audited cost report for the period(s) covering the state fiscal year." LA Ex. 5, at Item 1, Pages 10i(6) and 10i(7); LA Ex. 7, at Item 1, Page 10h.[4] Moreover, SPA 97-04 specifically states that "DSH payments to public state-operated hospitals are retrospective." LA Ex. 7, at Item 1, Page 10h.[5] While SPA 95-30 does not use the term "retrospective," it includes a provision for recovery if "at audit or final settlement . . . the actual uncompensated costs are determined to be less than the estimated uncompensated costs." LA Ex. 5, at Item 1, Page 10i(7). In addition, both State plan amendments provide that DSH payments to these hospitals "are equal to one hundred (100%) of the hospital's net uncompensated costs" subject to adjustment to ensure Louisiana does not exceed its DSH allotment. LA Ex. 5, at Item 1, Page 10i(5); LA Ex. 7, at Item 1, Page 10h.

Louisiana offers no reading of this plan language that would support a conclusion that Louisiana intended its interim payments, based on estimates, to be prospective payments that would not be adjusted to the actual, audited UCC of each hospital.

The external evidence of intent also supports CMS's position regarding the methodology adopted, not Louisiana's. When CMS was considering whether to approve SPA 97-04, CMS requested that Louisiana clarify whether Louisiana's reference to "interim payments" and "final payment based on the audited cost report" (which CMS described as "features normally associated with a cost-based, retrospective payment system") meant that Louisiana intended to adopt a retrospective system for DSH payments, rather than a prospective system. CMS Ex. 7, at 4. In response, Louisiana stated: "DSH payments to state hospitals are retrospective. DSH payment[s] to other hospital groups are prospective." *Id*. This contemporaneous evidence indicates that Louisiana clearly understood the consequences of the language it used for DSH payments to State hospitals.

Moreover, after CMS had notified Louisiana in December 2002 that it considered amounts identified by its review and State legislative audits as "overpayments" for which Louisiana was required to adjust the federal share, the Louisiana Medicaid Director sent a letter to LSU Health Sciences Center referring to the identified amounts as "overpayments," requiring submission of uncompensated care cost forms for the relevant

[4] Louisiana also provided a copy of SPA 03-26, applicable to SFYs 04 and 05, which states: "Final payment will be based on the uncompensated cost data per the audited cost report for the period(s) covering the state fiscal year." LA Ex. 10, at Item 1, Page 10k(1); LA Br. at 5 n. 3. This provision indicates that it supersedes SPA 10-10. Louisiana did not provide a copy of SPA 10-10, nor did it submit any amendment applicable to SFY 06. Thus, for parts of the disallowance period, Louisiana did not show what its plan provided, much less that it had a prospective payment system for DSH payments to State hospitals.

[5] SPA 97-04 defines a public State-operated hospital as a "hospital that is owned or operated by the State of Louisiana." LA Ex. 7, Item 1, Page 10h. Below, when we refer to public State-operated hospitals, we are using the State plan definition to include State-owned hospitals.

periods and in the future, and stating that "[d]etermination of the final DSH payment for SFY 2003 will be made upon final audit of the cost report and the uncompensated care cost calculation." CMS Ex. 5. Nothing in that letter suggests that Louisiana's Medicaid Director thought that the State plan permitted Louisiana to make final DSH payments to the hospitals based on estimated costs.[6]

In sum, other evidence in the record confirms what the plain language of the plan provides – that Louisiana intended to adopt a retrospective system for DSH payments under which the final, allowable payment amount is determined by the actual, audited UCC for the period for which the payment is made.

3. Louisiana's reliance on the fact that, for part of the disallowance period, the State plan did not specifically provide for recovery from public State-operated hospitals of the difference between estimated and actual UCC is misplaced.

Louisiana concedes that, "for the first seven quarters" of the disallowance period, "Louisiana's state plan provided for recoupment of excess DSH payments made to State-owned or –operated hospitals." LA Br. at 18. As noted above, the plan amendment in effect for that period, SPA 95-30, provided with respect to these State hospitals: "If at audit or final settlement . . . the actual uncompensated costs are determined to be less than the estimated uncompensated costs, appropriate action shall be taken to recover such overpayments." LA Ex. 5, at Item 1, page 10i(7).

Louisiana asserts, however, that SPA 97-04 superseded SPA 95-30 and deleted this provision, effective March 21, 1997.[7] Louisiana points to the provision of SPA 97-04 that states: "Appropriate action shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify." LA Ex. 7, at 2d page (Item 1, page 10c of Att. 4.19-A). According to Louisiana, this provision is narrow in scope, requiring recovery only "in two limited circumstances: where a hospital does not satisfy DSH qualifying criteria, and where 'overpayments result[] from erroneous data.'" LA Br. at 19. Louisiana argues that it is not plausible to interpret the phrase "erroneous data" to include any difference between actual and estimated UCC and that such an interpretation is "inconsistent with the State's reading of the plan language." LA Br. at 19. Louisiana also asserts that "the fact that

[6] Louisiana submitted a 2010 declaration of a Louisiana Medicaid Program Manager 2 who has managed Louisiana's hospital reimbursement activities since 1992, including oversight of DSH payments. LA Ex. 23. She attests that, during the disallowance period, Louisiana "made DSH payments to State hospitals based on estimates of UCC submitted by each hospital." LA Ex. 23, ¶ 4. Making DSH payments based on estimates of UCC, however, is perfectly consistent with a retrospective system in which interim payments are made based on estimates, but the amount paid must be adjusted retrospectively. Notably, the Program Manager's declaration is silent on the issue of whether Louisiana's State plan methodology called for Louisiana to make such adjustments.

[7] We note that Louisiana conceded that SPA 95-30 contained a recovery provision. Moreover, its argument based on SPA 97-04 would apply only to the period in which SPA 97-04 was in effect. *See* n. 4 above.

prior versions of Louisiana's State Plan contained language that referred specifically to recovery of the difference between estimated and actual UCC strongly suggests that the new language in SPA 97-04 did not impose such a requirement." *Id.*

Louisiana's interpretation of the language in SPA 97-04 regarding "overpayments resulting from the use of erroneous data" is reasonable. That provision is one of the general provisions for DSH payments to all hospitals in SPA 97-04, including the hospitals which are not public State-operated hospitals and which Louisiana had said it intended to pay using a prospective methodology. LA Ex. 7, at Item 1, Pages 10d, 10e.

Louisiana places too much weight, however, on the fact that SPA 97-04 did not contain any provision specifically authorizing recovery from the State hospitals if actual UCC were less than estimated UCC, as SPA 95-30 did. First, and most importantly, the absence of a recovery provision did not affect the State plan methodology for determining the allowable DSH payment amounts, which SPA 97-04 expressly described as a retrospective system and which the record shows Louisiana chose to continue to apply to State hospitals. CMS Ex. 7, at 4.

Second, it does not matter whether Louisiana's State plan specified that it would recover from the State hospitals any overpayment resulting from a difference between estimated and actual UCC. Once it was discovered that a hospital received more than it was entitled to under the State plan methodology, Louisiana was required by section 1903(d)(2) of the Act and the implementing regulations to seek to recover the overpayment from the hospital and to adjust the federal share of the overpayment within 60 days, unless an exception applied, regardless of whether Louisiana had recovered the overpayment from the hospital. 42 C.F.R. § 433.212.

In any event, Louisiana presented no evidence that it removed the recovery provision from SPA 95-30 because it no longer intended to recover any difference between estimated and actual UCC from the public State-operated hospitals. Indeed, the only evidence regarding the history of SPA 97-04 suggests that the recovery provision was dropped inadvertently, not as the result of any conscious decision. CMS had pointed out that Louisiana needed to revise SPA 97-04 to take into account pending State plan amendments, including SPA 95-30. Louisiana responded that the pending amendments had been resolved and that transmittal 97-04 had "been revised to flow through plan language resulting from the intervening transmittals." CMS Ex. 7, at 10.

Moreover, we question whether a State plan provision specifically permitting recovery from a provider is a necessary prerequisite for recovery of an amount in excess of what the State plan allows as reimbursement for Medicaid services. States have independent statutory authority to recover Medicaid overpayments to providers by requesting that CMS withhold Medicare payments to the provider. Act, § 1885; 42 C.F.R. § 447.31. In addition, in a situation where a state has effectively overpaid itself, adjustment of the federal share is more important than the specific source of the state funds used to make the adjustment.

Louisiana suggests that the differences between estimated and actual UCC were not "overpayments" to the hospitals. The remaining issue here is not whether those exact amounts were overpayments, however, but whether, as a result of Louisiana's failure to adjust for the differences, the hospitals received more reimbursement for any payment period than the amount to which they were entitled under the State plan as reimbursement for services provided during that period. The amounts remaining at issue in this case clearly fit that description. They have been adjusted to account for any underpayments of regular Medicaid payments identified by audit for the same period in which an excess DSH payment was made to a hospital. LA Exs. 14, 15.

Under the regulations implementing the statutory provisions regarding overpayments to Medicaid providers, the term "overpayment" is defined to mean "the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." 42 C.F.R. § 433.304. [8] As mentioned above, section 1902(a)(30)(a) of the Act requires that a Medicaid state plan specify payment methods for inpatient hospital services. Section 1903(a) of the Act makes FFP available for payments for services only if they are for "medical assistance" under the state plan. The implementing regulations cited above make it clear that FFP is available only in the amounts determined to be allowable reimbursement to providers under the approved methodology in the state plan. Under these provisions, the amounts remaining at issue clearly were overpayments to the hospitals. Thus, Louisiana was required to take steps to recover the amounts from the hospitals and to adjust the federal share, unless one of the statutory exceptions in section 1903(d)(2)(D) of the Act applied.

As we discuss next, neither of the statutory exceptions applies here.

4. The amounts paid to MCLNO do not qualify for the statutory exceptions to the requirement that a state adjust for any overpayment to a provider within 60 days of discovery of the overpayment.

As discussed above, section 1903(d)(2)(D) of the Act provides that "where the State is unable to recover a debt which represents an overpayment . . . made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof)." The implementing regulations at 42 C.F.R. Part 433, subpart F, provide that a state Medicaid agency is not required to refund the federal share of a provider overpayment "to the extent that the State is unable to

[8] Louisiana points out that CMS has said that DSH payments are not tied to specific Medicaid services. While it is true that the **amount** of DSH payments does not depend on the number of Medicaid services provided, the statute and regulations clearly treat DSH payments as an adjustment to the amount or rate otherwise payable for inpatient hospital services that the hospital provided during a particular period.

recover the overpayment because the provider has been determined bankrupt or out of business" in accordance with the provisions of section 433.318. 42 C.F.R. § 433.318(a).

Louisiana argues that DSH payments to MCLNO are uncollectable. The DSH payments to MCLNO account for $233,317,229 of the alleged overpayments ($164,746,994 FFP). LA Rebuttal Br. at 5. Louisiana acknowledges that, as a State-owned entity, MCLNO cannot file for bankruptcy in federal court. LA Br. at 28. Louisiana argues, however, that MCLNO is effectively "out of business" since, as a result of Hurricane Katrina, "its assets have been destroyed" and "it is barely (and only recently) operating a greatly reduced version of what used to be University Hospital." LA Br. at 28. Louisiana explains that, prior to Hurricane Katrina, there were two hospitals on the MCLNO campus, University Hospital and Charity Hospital, and that Charity Hospital was irreparably damaged by the hurricane and flooding and still has not reopened. LA Br. 25-26. Louisiana cites to testimony before Congress in December 2009 stating that, while University Hospital reopened in November 2006, the "capacity of the reopened University Hospital [is] considerably smaller than the former combination of Charity Hospital with University Hospital," and the "services provided at University Hospital have been much more limited than were offered before the storm." LA Br. at 26, *citing* LA Ex. 19.[9] Louisiana also points out that University Hospital is now called "Interim LSU Public Hospital," which suggests "the transient state of the facility" and that staffing remains a challenge in New Orleans, which is still recovering from the storm. LA Br. at 26-27.

CMS responds that Louisiana offered no documentation evidencing that MCLNO is "out of business" pursuant to the relevant Louisiana laws. CMS Response Br. at 23. CMS also presented evidence that Louisiana had claimed DSH payments for MCLNO that totaled $23,679,655.38 ($16,009,815 FFP) for the period October 2009 to September 2010. CMS Ex. 8 (Sampson Decl. ¶ 6). CMS says that these claims indicate that MCLNO is operational and is treating Medicaid beneficiaries.

With its reply brief, Louisiana submitted the declaration from its Medicaid Program Manager 2, who attests that Charity Hospital still had not reopened as of September 10, 2010, that University Hospital (a much smaller facility) was flooded and did not reopen until over a year after the hurricane, and that University Hospital now operates under the name Interim LSU Public Hospital. LA Ex. 29 (Gough Decl. ¶ 10). The Program Manager acknowledges, however, that this "interim facility uses the same provider number that had originally been assigned to MCLNO." *Id.*

[9] The testimony also discusses other factors that may have contributed to the reduction in services provided by MCLNO. According to the testimony, many patients received their care at MCLNO before the hurricane because Louisiana was using DSH payments to provide services to the uninsured and because New Orleans did not have sufficient community health clinics; the number of such clinics has increased since the hurricane, however, with assistance of federal funds (including $100 million in Deficit Reduction Act funds for the Gulf Region). LA Ex. 19.

We conclude that the "out of business" exception in the regulations does not apply. That exception is described in section 433.318(d) of the regulations as follows:

> *Out of business*. (1) The [State Medicaid] agency is not required to refund to CMS the Federal share of an overpayment at the end of the 60-day period following discovery if the provider is out of business on the date of discovery of the overpayment or if the provider goes out of business before the end of the 60-day period following discovery.
> (2) A provider is considered to be out of business on the effective date of a determination to that effect under State law. The agency must—
> (i) Document its efforts to locate the party and its assets. These efforts must be consistent with applicable State policies and procedures; and
> (ii) Make available an affidavit or certification from the appropriate State legal authority establishing that the provider is out of business and that the overpayment cannot be collected under State law and procedures and citing the effective date of that determination under State law.

Here, Louisiana presented no evidence to show that MCLNO was declared out of business under State law, and has not presented the documentation and affidavit or certification required by regulation for the exception to apply.

We also note that some of the overpayments to MCLNO were "discovered" by a State legislative audit by December 2002, well before Hurricane Katrina in 2005. The exception would not apply to those overpayments even if Hurricane Katrina had put MCLNO out of business, which it did not. *See* 42 C.F.R. § 433.316 (defining "discovery" of an overpayment for purposes of the requirement for refunding the federal share within 60 days); CMS Exs. 3, 4. Following notice from CMS that Louisiana should adjust the federal share of the identified overpayments, the Louisiana Medicaid Director suggested to the LSU Health Care Services Division that the hospitals provide "any justifications, such as physicians and CRNA costs, that could reduce or eliminate the overpayments." CMS Ex. 5, at 1. Subsequently, Louisiana argued to CMS that certain physician and some other costs should be included in calculating the UCC for each hospital. CMS Ex. 6.[10] Under the regulations, however, a state must refund the federal share of an identified overpayment within the 60-day period despite any unresolved dispute about the overpayment. 42 C.F.R. § 433.316(f). Moreover, a state may reclaim FFP for a downward adjustment to the overpayment amount only if the adjustment is properly based on an approved state plan, federal Medicaid law and regulations, and the appeals resolution processes specified in state administrative policies and procedures. 42 C.F.R. § 433.320(c). Thus, the fact that the hospitals challenged the findings did not excuse Louisiana's failure to return the federal share.

[10] Louisiana is not raising the issue of the physician and CRNA costs in this appeal. LA Reply Br. at 7-8.

Louisiana argues nonetheless that the Board should determine that its overpayments to MCLNO are otherwise "uncollectable" under section 1903(d)(2)(D) of the Act because the statutory language is "much broader" than the regulatory language. LA Br. at 29-30. According to Louisiana, recovering the overpayments to MCLNO would be contrary to the intent of Congress in providing for DSH payments to a hospital such as MCLNO.

These arguments have no merit. First, the implementing regulations interpret the exception for otherwise uncollectable overpayments to apply only in circumstances where the provider is or goes out of business under state law **within the 60-day period** and a state can document that it was unable to recover the overpayment as a result. Congress has taken no action to overturn this interpretation, even though the regulations were promulgated in 1989, more than 20 years ago.

Second, even if there were no implementing regulations, we would conclude that the overpayments to MCLNO did not qualify for the statutory exception to the requirement that a state repay the federal share of any identified overpayment to a provider. Section 1903(d)(2)(D) of the Act provides an exception in any case "where the State is **unable to recover a debt** that represents an overpayment" on account of such debt being discharged in bankruptcy or "otherwise being uncollectable." (Emphasis added.) Here, the overpayments were made to a State-owned hospital, MCLNO. Louisiana does not claim that it is unable to recover a debt one State entity owes another. Nor does Louisiana cite to anything in the wording or history of the statute indicating that Congress intended that a state could effectively make Medicaid overpayments to itself, and then avoid repaying the federal share merely because the specific state entity that received the overpayments might have difficulty repaying them.

Finally, as discussed above, the hospital-specific DSH limits were put in place precisely because states were making DSH payments to state hospitals in excess of their costs, claiming FFP, and then using the funds for other state purposes. Thus, CMS's position here is consistent with the purposes of DSH payments.

5. The disallowance is not inconsistent with statements CMS made in the preamble to the 2008 regulations implementing the 2003 statutory changes and in response to an OIG audit.

Louisiana also argues that the disallowance should be reversed because CMS determined that the changes made in the December 2008 regulations implementing the 2003 statutory changes would be applied only prospectively. Louisiana contends that the 2008 regulations (which it refers to as the "Final DSH Audit Rule) for "the first time ever, . . . articulated a federal-law requirement that States reconcile estimated and actual UCC." LA Br. at 15, *citing* 73 Fed. Reg. at 77,951, *codified at* 42 C.F.R. § 455.304(d)(2).

In support of this position, Louisiana points out that the Final DSH Audit Rule was not effective immediately. Louisiana points to preamble language stating that "to the extent that audit findings demonstrate that DSH payments exceed the documented hospital-

specific cost limits, CMS will regard them as representing discovery of overpayments" beginning in Medicaid State plan rate year 2011. LA Br. at 15, *citing* 73 Fed. Reg. at 77,906. Louisiana also relies on the following preamble language:

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

73 Fed. Reg. at 77,906. Louisiana argues that recent CMS guidance confirms the "core principles" from the preamble, namely, that CMS will not require retroactive collection of DSH overpayments for past years, but will permit states time to improve their DSH payment methodologies to avoid circumstances in which DSH payments exceed the federal statutory limits. LA Br. at 17. According to Louisiana, the "strictly *prospective* nature of the regulation leaves no doubt that federal law, at least during the disallowance period, *never* mandated the approach that CMS now purports to require." *Id.* (italics in original).

This argument has no merit. As discussed above, federal law has always required states to reimburse hospitals according to the methodology in the approved Medicaid state plan, and, with very limited exceptions that do not apply here, requires states to return the federal share of any payments to hospitals in excess of the amount determined according to the state plan.

Louisiana conflates two separate issues: (1) whether a state with a retrospective reimbursement system in its state plan for determining DSH payments is required to reconcile estimated to actual costs; and (2) whether section 1923(g) of the Act requires a state to reconcile estimated UCC to actual UCC for each hospital, even if the state adopted a prospective DSH payment methodology in its state plan.

A careful reading of the preamble to the Final DSH Audit Rule evidences this distinction. First, the statutory provision being implemented is section 1923(j) of the Act, which imposed new requirements with respect to hospital-specific DSH limits, including the requirement for "independent certified audits." Thus, while the preamble language on which Louisiana relies refers to "audits," it does not mean the type of reviews or audits that a state previously conducted based on its state plan methodology for determining allowable payment amounts. Instead, 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. Indeed, the stated purpose of the transition provision at 42 C.F.R. § 455.304(e) is to "ensure a period for developing and refining reporting and auditing techniques." The transition period was "not intended to preclude review of DSH payments and discovery of overpayments" by means other than the independent certified audits pursuant to the new requirements. 73 Fed. Reg. at

77,908. Thus, the provision for a transition period cannot reasonably be read to preclude CMS from taking the disallowance here.

The preamble further explains that, while CMS permits states to adopt plan methodologies that define allowable costs for DSH purposes, CMS has always interpreted section 1923(g) to require use of actual UCC in determining the DSH limit for any hospital. 73 Fed. Reg. at 77,906,908. The preamble recognized, however, that states typically had chosen to base DSH payments on estimated costs without reconciliation to actual costs. *Id.* Moreover, the preamble discussion indicates that there may have been some confusion about what costs and revenues could or should be included in calculating UCC, that some hospitals might need to revise their accounting systems, and that auditors may need to develop methods to segregate certain costs and revenues until hospitals revised their systems. *Id.* Here, however, CMS is not applying the cost and revenue provisions of the Final DSH Audit Rule or any clarification in the preamble. Instead, CMS accepted the excess payment amounts identified by Louisiana based on state audits or as-filed cost reports and set out in an August 2008 submission to CMS before the Final DSH Audit Rule was published. LA Ex. 23 (Phillips Decl. ¶ 4).

Therefore, we conclude that nothing in the Final DSH Audit Rule or its preamble precludes the disallowance here. That disallowance is based on longstanding statutory and regulatory provisions and the plain language of Louisiana's State plan, not on any findings of independent certified audits pursuant to section 1923(j) of the Act and the Final DSH Audit Rule.

We also reject Louisiana's similar argument that CMS should be precluded from taking the disallowance because of how CMS responded to an OIG recommendation in a draft audit report. LA Br. at 13-15, *citing* LA Ex. 12. That audit consolidated findings regarding a number of states the OIG had determined did not comply with hospital-specific DSH limits in section 1923(g) of the Act, including states with prospective DSH payment systems. LA Ex. 12. The OIG recommended that CMS "ensure that the monetary recommendations concerning DSH payments that exceeded the hospital-specific limits have been resolved." *Id.* 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." LA Ex. 12, App. B, at 2. The issue here, however, is not whether CMS was required to recoup federal funds that exceeded hospital-specific limits determined by the OIG, but whether CMS was authorized to recoup the federal share of the amounts at issue here, given the methodology Louisiana adopted in its State plan. We also note that the OIG's consolidated report was not issued until March 16, 2006, long after CMS had notified Louisiana that it had to adjust the federal share of the DSH overpayments already identified.

In sum, CMS's statements do not provide a basis for reversing this disallowance.

Conclusion

For the reasons stated above, we uphold the disallowance in the amount as revised during Board proceedings.

_____/s/_____
Leslie A. Sussan

_____/s/_____
Constance B. Tobias

_____/s/_____
Judith A. Ballard
Presiding Board Member