Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Alaska Department of Health and Social Services
Docket Nos. A-06-99, A-06-100, A-07-61
Control Nos. AK/2005/001/MAP, AK/2005/002/MAP, AK/2006/001/MAP
Decision No. 2103

DATE: July 31, 2007

DECISION

The Alaska Department of Health and Social Services (Alaska or State) appealed determinations issued by the Centers for Medicare & Medicaid Services (CMS) disallowing $42,263,333 in Medicaid funding that Alaska claimed for the period July 1, 2005 - September 30, 2006. The disallowances involve claims that relate to supplemental payments Alaska made to private hospitals above the basic Medicaid rates for inpatient hospital services, or to payment adjustments Alaska made to hospitals that disproportionately serve Medicaid recipients and uninsured persons. The appeals were consolidated because they present similar issues.

We uphold CMS's determinations disallowing Alaska's claims. Alaska claimed the federal funds in connection with payments it made pursuant to a series of written "Proportionate Share Payment Agreements" and "Disproportionate Share Hospital Agreements" between Alaska and several hospitals in 2005 and 2006. Payments made pursuant to these agreements were neither authorized by Alaska's Medicaid State plan nor consistent with the governing federal Medicaid statutes and regulations. Under the agreements, the hospitals could not use the payments to offset costs that the hospitals incurred in providing inpatient services to Medicaid recipients or the uncompensated costs of providing care to high volumes of Medicaid recipients and uninsured persons. Instead, the funds paid to the hospitals were passed through the hospitals and used to fund non-Medicaid State programs. Under the circumstances before us, Alaska's interpretation of its State plan to authorize these payments was not reasonable, and we thus sustain the disallowances.

We further conclude that CMS used an appropriate process when it issued the disallowances. As discussed below, the central issues presented involve whether claims relating to specific supplemental and disproportionate share hospital payments were allowable expenditures under the approved State plan and federal requirements for covered services provided to eligible individuals. Accordingly, CMS properly followed the disallowance process set forth at 42 C.F.R. § 430.42.

Law and regulations

The federal Medicaid statute, found in title XIX of the Social Security Act (Act),[1] provides for joint federal and state financing of medical assistance for certain needy and disabled persons. Act §§ 1901, 1903. Each state that chooses to participate administers its own Medicaid program under broad federal requirements and the terms of its own "plan for medical assistance," or state plan, which must be approved by CMS on behalf of the Secretary of Health and Human Services (HHS). Act § 1902; 42 C.F.R. §§ 430.10-430.16. The state plan must contain "all information necessary for CMS to determine whether the plan can be approved . . . ." 42 C.F.R. § 430.10. Once the state plan is approved, a state becomes entitled to receive federal reimbursement, or "federal financial participation" (FFP), for "an amount equal to the Federal medical assistance percentage . . . of the total amount expended . . . as medical assistance under the State plan." Act §§ 1903(a). Section 1905(a) of the Act defines the term "medical assistance" as "payment of part or all of the cost" of specified services and care when provided to Medicaid eligible individuals under the state plan. State plans must be amended when necessary to take into account "[c]hanges in Federal law, regulations, policy interpretations, or court decisions." 42 C.F.R. § 430.12(c)(i).

Sections 1902(a)(2), 1903(a) and 1905(b) of the Act require states to share in the cost of medical assistance and in the cost of administering the approved state plan. Under section 1903(a)(1) of the Act, FFP is allowable in connection with an approved state plan only when there is a corresponding state expenditure for covered medical assistance to Medicaid

[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

recipients. Section 1902(a)(19) of the Act requires a state plan to "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interest of the recipients." Under section 1902(a)(30)(A) of the Act, a state plan must "provide such methods and procedures relating to the utilization of, and 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. . . ."

Under section 1904 of the Act and 42 C.F.R. § 430.35, CMS may withhold payments to a state if, after giving the state reasonable notice and opportunity for a hearing, CMS finds that the state plan no longer complies with section 1902 of the Act or that in the administration of the plan there is a failure to comply substantially with any such provision. Withholding means that, on a prospective basis, Medicaid payments for part or all of the state's program will not be made until the Secretary determines that the state is no longer out of compliance. 42 C.F.R. § 430.35.

In contrast with the compliance process, 42 C.F.R. § 430.40(a)(1) provides that CMS may defer on a retrospective basis a state's claim for FFP if CMS questions the claim's "allowability and needs additional information in order to resolve the question." If CMS thereafter determines that the state is not entitled to FFP for "a claim or portion of a claim" because it is unallowable under the approved plan, then CMS issues a disallowance notice that contains, among other things, findings of fact and law, and references to regulations, guides or instructions supporting the action taken. 42 C.F.R. § 430.42. The state may request reconsideration of the disallowance determination by appealing to the Board. 42 C.F.R. § 430.42.

The Medicaid regulations governing payment for inpatient hospital services are set forth at 42 C.F.R. Part 447, subpart C. A state plan must "specify comprehensively the methods and standards used . . . to set payment rates" for inpatient hospital services. Act § 1902(a)(13); 42 C.F.R. § 447.252(b). A state plan may authorize supplemental payments to hospitals above the basic Medicaid payment rate so long as the payments do not exceed the applicable inpatient hospital services upper payment limits

(UPLs). 42 C.F.R. §§ 447.271- 447.272.[2] Rates subject to the inpatient services UPLs are "set by the agency to pay for inpatient services furnished by hospitals." 42 C.F.R. § 447.272(a). The UPL regulations in effect during the period relevant here specified that the "aggregate Medicaid payments to a group of [privately-owned and operated facilities] may not exceed the upper payment limit," defined as "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles. . . ." 42 C.F.R. § 447.272 (2004-2006). Section 1902(a)(30) of the Act, mentioned above, serves as the statutory authority for the UPL regulations. 42 C.F.R. § 447.250(b); see also 66 Fed. Reg. 3147, 3166-67 (Jan. 12, 2001).

The Act also establishes that Medicaid state plans must take into account "the situation of hospitals which serve a disproportionate number of low-income patients with special needs." Act § 1902(a)(13)(A)(iv). This requirement reflects a congressional finding that "public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement," have high levels of uncompensated care costs, and therefore need additional financial support in order to continue providing care to the needy. H.R. Conf. Rep. No. 208, 97th Cong. 1st Sess. 962 (1981), reprinted in 1981 U.S.C.C.A.N. 1010, 1324.[3]

Accordingly, section 1923 of the Act requires state plans to provide for "an appropriate increase in the rate or amount of payment for [inpatient hospital] services" furnished by disproportionate share hospitals (DSHs). Act § 1923(a)(1)(B). Notably, Congress amended the Act in 1993 to impose hospital-specific limits on DSH payments reflecting uncompensated hospital costs:

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[2] Medicaid regulations setting upper limits on payments for outpatient and clinic services are set forth separately at 42 C.F.R. Part 447, subpart F.

[3] See also H.R. Rep. No. 391(I), 100th Cong. 1st Sess. 524 (1987), reprinted in 1987 U.S.C.C.A.N. 2313, 2344 (indicating that the purpose of requiring disproportionate payment adjustments was to assure that Medicaid payments **"meet the needs** of those facilities which, because they do not discriminate in admissions against patients based on source of payment or on ability to pay, serve a large number of Medicaid-eligible and uninsured patients who other providers view as financially undesirable" (emphasis added)).

> A payment adjustment . . . shall not be considered to be consistent with [the Act's DSH payment adjustment methodology requirements] with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services . . . 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.

Section 1923(g)(1)(A) of the Act.

Background on the UPLs and hospital specific limits on DSH payments

The majority of the disallowed claims at issue concern supplemental payments to privately-owned hospitals based on the Medicaid UPLs for inpatient hospital services. The remaining claims relate to Medicaid DSH payment adjustments. Some background on the development of the UPL and DSH payment statutes and regulations, and their application by states, is helpful to understand the federal requirements that govern this appeal.

Before March 2001, the Medicaid UPL regulations set an upper limit on overall aggregate payments to all facilities and a separate aggregate upper limit on payments to State-operated facilities for Medicaid inpatient services. Because private facilities were grouped with non-state governmental facilities (i.e., county-owned facilities) for the purpose of determining the limits, states were able to develop payment methodologies that enabled them to claim excessive reimbursement, thereby causing federal Medicaid spending to increase rapidly. As CMS explained in a Federal Register notice proposing to change the rule:

> By developing a payment methodology that sets rates for proprietary and nonprofit facilities at lower levels, States can set rates for county or city facilities at substantially higher levels and still comply with the current aggregate upper payment limit. The Federal government matches these higher payment rates to public facilities. Because these facilities are public entities, funds to cover the State share may be transferred from those facilities (or the local government units that operate them) to the State, thus generating increased Federal funding with no net increase in State

> expenditures. This is not consistent with the intent of statutory requirements that Medicaid payments be economical and efficient.

65 Fed. Reg. 60,151, 60,152 (October 10, 2000). This situation, CMS wrote in its proposed rule change, "creates a financial incentive for States to overpay non-State-operated government facilities because States, counties, cities and/or public providers can, through this practice, lower current State or local spending and/or gain extra Federal matching payments." Id.

To support its proposed rule revision, CMS also cited findings and testimony before Congress by the Office of the Inspector General and the General Accounting Office (GAO), that states' "enhanced payment programs" and "associated financing mechanisms" had several characteristics in common, including: the enhanced payments were not based on the actual cost of providing services or increasing the quality of care to Medicaid recipients; the counties used "little or none" of the payments to provide services to Medicaid recipients – most of the funds were sent back to the states' general funds or used to repay the loans that had been made to initiate the transactions; states were able "to reduce their share of Medicaid costs and cause the Federal government to pay significantly more than it should for the same volume and level of Medicaid services; and states effectively recycled the federal funds to generate additional FFP. Id. at 60152. In sum, the GAO testified, the states took advantage of a technicality to "replace State Medicaid dollars with Federal Medicaid dollars," thereby "violat[ing] the basic integrity of Medicaid as a joint Federal/State program." Id. at 60,152-60,153.

In response to these findings, CMS revised section 447.272 of the Medicaid regulations to require states to calculate three separate aggregate UPLs to correspond to three distinct categories of providers: State government-owned or operated facilities; non-state owned or operated facilities; and privately-owned and operated facilities. 66 Fed. Reg. 3147, 3175-76 (January 12, 2001). Particularly important in this case, CMS explained in the preamble to the final rule why, under the revised regulations, a state could not redirect supplemental payments for inpatient institutional services to pay for non-institutional services. Specifically, CMS noted that it had received comments suggesting that it should permit states to use supplemental payments not exceeding the UPLs to: 1) pay for non-Medicaid health services that would "result in net savings to Medicaid" such as "training community-care aides"; 2) "reduce institutional bias and . . . be based on removing people from

nursing homes"; and 3) pay "nursing homes so there will be adequate operating capital." Id. at 3167. In response, CMS wrote that the Act has several separate provisions that allow states to "legitimately redirect Medicaid funding" to support such services. Id. CMS continued,

> Under section 1115 of the Act, States can operate programs that expand eligibility and/or include services not otherwise covered by Medicaid, if these programs do not result in increased Federal spending. Under section 1915(c) of the Act, States can establish home and community-based programs as an alternative to institutional care. The main distinction between these programs and similar programs that may be funded under the former UPLs is that States would be required to fund their share of the costs as required by the Medicaid statute. **To operate similar programs under the UPLs, States would have to represent expenditures for the medically necessary provision [of] institutional care for the purpose of claiming Federal matching funds, and then have those institutions transfer Federal funds to support non-institutional services. The representation is misleading since by definition the funds would not be used by the institution to provide medically necessary care and services to its inpatients, but rather to support some type of alternative program. We believe these types of funding arrangements completely undermine the integrity of the Medicaid program.**

Id. (emphasis added). In conclusion, CMS wrote that it was the agency's intent that under the new regulations Medicaid payments claimed as nursing home or other institutional services expenditures "will in fact be paid to and retained by those facilities to offset the costs they incurred in furnishing Medicaid services to eligible individuals." Id.

Not unlike the evolution of the UPL regulations, the history of the Medicaid DSH statutes shows how Congress refined the law to respond to state financing practices that diverted Medicaid FFP to support non-Medicaid state costs. Most notably, a House Report explained the reasoning behind the 1993 amendment to the Act's DSH provisions codified as section 1923(g)(1)(A) of the Act, as follows:

> The Committee is concerned by reports that some States are making DSH payment adjustments to hospitals that do not provide inpatient services to Medicaid

beneficiaries. **The purpose of the Medicaid DSH payment adjustment is to assist those facilities with high volumes of Medicaid patients in meeting the cost of providing care to the uninsured patients that they serve, since these facilities are unlikely to have large numbers of privately insured patients through which to offset their operating losses on the uninsured.** It is difficult for the Committee to understand how the payment of a Medicaid DSH payment adjustment to a facility that has no Medicaid inpatients can be justified on statutory or policy grounds.

. . .

The Committee is also concerned by reports that some States have made DSH payment adjustments to State psychiatric or university hospitals in amounts that exceed the net costs, and in some instances the total costs, of operating the facilities. According to such reports, once received by the State hospital, these excess Medicaid DSH payments are transferred to the State general fund, where they may be used to fund public health or mental health services, to draw down more Federal Medicaid matching funds, or to finance other functions of State government, such as road construction and maintenance. A parallel transaction can occur at the local level. The Medicaid program is intended to assist States in paying for covered acute and long-term care services for the poor. In the view of the Committee, use of Federal Medicaid funds for unrelated purposes, such as building roads, operating correctional facilities, balancing State budgets, is a clear abuse of the program.

The Committee bill limits the amount of payment adjustments to State or locally-owned or operated DSH hospitals to the costs (as determined by the Secretary) these facilities incur in furnishing inpatient or outpatient services to Medicaid-eligible patients and uninsured patients, net of any payments received by the facility under Medicaid (other than the DSH payment adjustment) and any out-of-pocket payments received from uninsured individuals. For this purpose, payments made by a State or locality to a hospital for services provided to indigent patients are not treated as a source of third party payment.

H.R. Rep. 103-111, 103rd Cong. 1st Sess. 211-12 (1993), reprinted in 1993 U.S.S.C.A.N. 378, 578-79.

Background of the disputed UPL and DSH claims

Beginning in April 2000, Alaska's Medicaid State plan provided for supplemental payments not exceeding the inpatient hospital UPLs for public hospitals. Ak. Att. A ¶ 16. Alaska called these payments "Proportionate Share Incentive Payments" or "Proshare payments." Alaska submitted State Plan Amendment (SPA) No. 02-005, dated May 31, 2002, after CMS published the 2001 revision of the UPL regulations. Ak. Ex. 3. Alaska wrote in the cover letter to the proposed amendment that it was "updat[ing]" the "Methodology and Criteria for Proportionate Share Payments to Hospitals . . . to be in compliance" with the revised regulations. Id. The State wrote that it was changing the calculation of the UPLs from a "single aggregate category" to the three categories set forth in 42 C.F.R. § 447.272: 1) state government-owned or operated facilities; 2) non-state government-owned or operated facilities; and 2) privately-owned and operated facilities. Id. Reflecting the revised categories, the amendment included a new section establishing supplemental payments to private hospitals under the UPLs, titled "Private Hospital Proportionate Share Incentive Payments," (which the State sometimes refers to as "Private Proshare" payments). Id. Alaska wrote in the cover letter transmitting the proposed amendment that "[b]ecause this is a change in describing the categories for payment, and not a change in the actual payment amount, there is no bugetary [sic] impact." Id.

Between June and October 2002, Alaska and CMS exchanged a number of communications about the proposed amendment, including questions and responses about the wording of the amendment and the private hospital Proshare payment methodology. Ak. Exs. 4, 5, 6. Alaska made changes to the amendment's language in response to CMS's questions and comments, and CMS approved the revised SPA 02-005 on October 15, 2002. Ak. Exs. 7, 28.

The section of the approved amendment that addresses Private Proshare payments states that, "[t]o ensure continued access [to inpatient hospital services], the [State] will make a Private Hospital Proportionate Share (PHPS) incentive payment, and may require specific services to be performed by, a hospital that qualifies." Id. To calculate the total funds available in the Private Proshare program, the amendment provides in part that "[t]he private hospital facility-specific differences between UPL and estimated Medicaid payments are added together to calculate the statewide total for additional payments to all privately

owned hospitals for inpatient services." Id. The amendment also states that a "qualified private hospital" under the PHPS program is one that, among other things, "enters into a written PHPS agreement with the [State] to provide additional services under Section XV-6 . . . ." Id. The amendment further states that Proshare payments will be distributed "based on the number of prospective encounters the hospital agrees to perform . . . ." Id.

Following CMS's approval of the SPA, Alaska entered into proportionate share payment agreements with several private hospitals and began to make payments to the hospitals based on the agreements during the 2003 federal fiscal year. Ak. Ex. 9; Ak. Br. at 12. On June 9, 2003, the State submitted a form CMS-37 to CMS, estimating it would expend roughly $133 million FFP for the quarter ending September 30, 2003. CMS Ex. 5; CMS Br. at 21. Following that quarter, however, the State reported and made claims for approximately $182 million FFP in actual expenditures for the period. Id. Alaska indicated to CMS that a primary reason for the difference between its estimated and actual FFP claims was the State's Private Proshare payments.[4] Ak. Ex. 8. Further, CMS observed that the State's expenditures claimed as relating to Medicaid inpatient services had dramatically risen from roughly $29.5 million for the quarter ended September 30, 2002, to approximately $91 million for the quarter ended September 30, 2003. CMS Br. at 22; CMS Ex. 5.

Instead of immediately paying the State's claims, CMS issued a letter dated February 11, 2004 deferring $35,784,040 in FFP. Ak. Ex. 8. CMS stated in the notice that it would defer the funds until Alaska provided "sufficient information to clarify calculation methodology, and allocation of payments to private hospitals." Id. The letter further provided that "[t]he inconsistencies with SPA TN 02-005 will also be addressed." Id.

A series of communications between CMS and the State involving the Private Proshare program ensued. Ak. Exs. 9-11. The record indicates that it was during this period that Alaska first gave CMS copies of the written agreements between the State and the private hospitals under the Private Proshare program. Ak. Ex. 9.

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[4] Alaska contends that when it submitted the proposed amendment it anticipated that the approval process would take a longer period of time and that the Private Proshare payments would not begin until the 2004 fiscal year. Accordingly, the State predicted the amendment would have no budget impact for the 2003 fiscal year. Ak. Att. A ¶ 20.

In a document dated February 27, 2004, after receiving copies of the agreements, CMS asked the State a series of additional detailed questions about the Proshare payments. CMS began its inquiry, "[p]lease explain how the expenditures related to these agreements are in compliance with the approved State plan?" Ak. Exs. 10-11. Alaska answered CMS's questions on June 11, 2004, stating in part:

> Hospitals are reimbursed by the state for Medicaid services they have already performed for Medicaid eligible patients in compliance with the approved Alaska State Plan. The hospitals, serving statewide and regional populations, may then choose to arrange with local community providers to perform certain services for which they are paid through their distribution of the PHPS payments. . . .

Ak. Ex. 11. Responding to CMS's question whether the services specified under the agreements were covered under Alaska's Medicaid State plan and provided to Medicaid eligible individuals, Alaska wrote, "[t]he Medicaid State Plan may cover these services [and] services may be provided to Medicaid eligibles." Id.

In 2004 the Health and Human Services Secretary, Tommy Thompson, met with Alaska Governor, Frank Murkowski. While the parties here dispute what matters were discussed between the two officials, the record includes a letter dated October 8, 2004, from Secretary Thompson to Governor Murkowski purporting to memorialize an agreement made during the meeting. Ak. Ex. 12. The Secretary stated that the letter's purpose was to "follow-up our recent discussions concerning the financing obstacles presently faced by the Alaska Medicaid program." Id. The Secretary also wrote that he "appreciate[d] that [CMS and Alaska] can work in a cooperative manner to ensure that health care is provided to our most vulnerable populations while continuing to preserve the fiscal integrity of the Medicaid program." Id. The Secretary then stated that he had directed CMS to release the "deferred funds totaling $35,784,040 for certain hospital payments claimed by Alaska" and that the State would "have the opportunity to make additional claims for Federal funding associated with these hospital payments" through Alaska's 2005 fiscal year. Id. The Secretary concluded:

> I appreciate your cooperation and willingness to develop alternative financing of these hospital payments effective July 1, 2005. I have informed CMS that the Alaska Medicaid program will be submitting the necessary

> State plan change to create the necessary "firewall" between funding sources to ensure appropriate matching requirements are met and that funds are used to serve individuals in the Medicaid program. Id.

Notwithstanding its receipt of the letter, Alaska continued to make Private Proshare payments. Nearly three months later, CMS wrote to the State asking it to provide further information on the "current flow of funds for the State's 3 Proshare payments" and to detail the source of the State's shares of the payments. Ak. Ex. 13. Alaska responded on March 11, 2005, stating that federal funds for the program were paid through the State to qualifying facilities and that State matching funds were paid to the facilities from the State's General Fund, based on State legislative appropriations. Ak. Ex. 14.

After receiving Alaska's response, CMS sent the State a letter on May 25, 2005, asserting that it "remain[ed] concerned that the funding of payments to certain private providers appears to be inconsistent with portions of the Act." Ak. Ex. 15. CMS referred to the October 8, 2004 letter from Secretary Thompson to Governor Murkowski and wrote that it had not "received plan changes that would end the payments in question as of June 30, 2005, nor has the State contacted us with alternative funding of the non-federal share of these payments." Id.

Responding to CMS's May 25, 2005 letter and prior communications, Alaska's Medicaid Director sent a letter to CMS on June 16, 2005, asking CMS to clarify its concerns and the issues surrounding the UPL payments in anticipation of a conference call between the parties scheduled for June 28, 2005. Ak. Ex. 16. Alaska asked CMS: 1) to identify the specific sections of the Act with which the Proshare payments were inconsistent; and 2) to clarify the meaning of Secretary Thompson's October 8, 2004 letter, in particular, by specifying "what legal issues are to be addressed by a state plan change to 'create the necessary 'firewall' between funding sources to ensure appropriate matching requirements are met . . . .'" Id. The State wrote, "from our point of view we are making private hospital payments in accordance with an approved state plan and federal regulation and law." Id. Further, Alaska wrote, CMS never defined or explained the inconsistencies or legal issues CMS expects Alaska to address in a State plan change. Id. According to declarations submitted with Alaska's appeal, the conference call took place, and at the end of the call, CMS staff told the State it would send a letter detailing its concerns about the Private Proshare program. Ak. Att. A ¶ 30; Ak. Att. B ¶ 13.

Notwithstanding ongoing communications about the Private Proshare program, Alaska entered into several new Private Proshare agreements for State fiscal year 2006 with Providence Health System - Washington d.b.a. Providence Health System in Alaska operating Providence Alaska Medical Center (Providence Hospital). The agreements related to children's medical care, mental health clinic assistance, rural health clinic assistance, and single point of entry psychiatric (SPEP) services. Ak. Exs. 17-21, 29. All of the agreements specified at the outset that: "To ensure continued access and reduce hospitalizations, the Department will make a proportionate share payment to the Hospital for the purpose of funding services administered by qualified community service providers. . . ." Id. In all but the SPEP agreement, the Private Proshare agreements required the hospital to "[a]ccept and distribute" the proportionate share payments it received from the State to "community service provider[s]" identified and monitored by the State. Providence Hospital retained only a percentage of the payments it received as an "administrative fee." Ak. Exs. 17-20, 29. The SPEP agreement stated that Providence Hospital "agree[d] to perform the following: . . . [p]rovide Single Point of Entry hospital services to Medicaid recipients through its facilities." Ak. Ex. 21.

On January 25, 2006, CMS sent to Alaska a letter explaining in detail its concerns with the Private Proshare payments. Ak. Ex. 24. CMS wrote that the Private Proshare payments made under the agreements with Providence Hospital were inconsistent with sections 1902(a), 1903(a) and 1905(b) of the Act. Id. CMS alleged, among other things, that the payments were not for covered Medicaid services but for "the operation of a non-Medicaid grant program. . . ." Id. CMS wrote that, because the agreements required the providers to return unexpended funds upon the State's request, the State plan's payment rate did not reflect net expenditures by the State, and the refund provision "indicat[ed] that the full payment amount proposed in the State plan [was] not required to ensure Medicaid beneficiaries access to the providers' services." Id. Thus, CMS concluded, the payments were inconsistent with section 1902(a)(30)(A) of the Act, requiring payment rates to be consistent with "efficiency, economy and quality of care." Id. CMS alleged further that, because the State was using funds claimed for inpatient hospital services to reimburse other, non-hospital providers for non-inpatient hospital services, the payments were inconsistent with section 1902(a)(19) of the Act, requiring that care and services will be provided consistent with "simplicity of administration and the best interests of the recipients." Id. The best interests of Medicaid recipients were not served, CMS wrote,

where Medicaid funds were diverted to non-Medicaid programs to be used for "purposes that were not expressly described or approved in the State plan." Id. CMS additionally alleged that the State had failed to comply with section 1902(a) of the Act and 42 C.F.R. § 430.10 because "a major portion of the methodology" for determining how the funds ultimately were distributed was not reflected in the State plan. Id. CMS further wrote that the hospitals' redistribution of payments for State purposes "is an impermissible donation (if voluntary) or tax (if mandatory) because that use is directly tied to the amount of the Medicaid payment." Id.

On May 31, 2006, CMS issued the first determination concerning the supplemental payments appealed in this case, disallowing $21,357,099 in FFP claimed for the July 1, 2005-September 30, 2005 period. Ak. Ex. 26. Citing sections 1902(a), 1903(a) and 1905(b) of the Act, CMS wrote that the disallowance was based on its finding that the Proshare payments "were not in fact for an allowable purpose under the Medicaid statute or the approved State plan due to the required redirection of the payments to other entities." Id. Citing the written agreements between Alaska and Providence Hospital, CMS concluded that the "payments did not actually serve the purpose of paying for covered hospital services . . . [but] were diverted for services or other functions of . . . community service providers, which are not authorized under the approved State plan." Id. CMS stated that section 1902(a)(19) of the Act requires that supplemental payments not exceeding the UPLs be used "to support quality care and services of Medicaid inpatient hospital services, and are not diverted for other purposes . . . ." Id. Also, CMS wrote, because the State requires the funds to be "redirected to non-hospital providers," the payments remained under Alaska's "administrative control" and did not represent "net expenditures" of the State within the meaning of section 1903(a)(1) of the Act.

On January 31, 2007, CMS issued a second notice of disallowance of FFP relating to Alaska's supplemental payments. Ak. Ex. 35. The second determination related to claims for the July 1, 2006 - September 30, 2006 period made pursuant to agreements between the State and Providence Hospital for State Fiscal Year 2007. Ak. Exs. 30-34. The wording in the underlying agreements was the same as that used in the agreements underlying the preceding year's Private Proshare claims. Id. The disallowance was in the amount of $17,132,118. Ak. Ex. 35. CMS used the same rationale and language to support the second disallowance as it had to support the earlier determination. Id.

Background of the disputed DSH claims

Alaska first received approval to make DSH payments to hospitals under a 1991 State plan amendment. Ak. Att. A at 33. In March 2002, Alaska submitted a proposed State plan amendment, SPA 02-002, adding two new categories or classifications under which an "eligible hospital [could] receive a DSH payment." CMS Ex. 3 at 00228. Those two classifications were "mental health clinic assistance services" and "substance abuse treatment services." Id. During the following several weeks, CMS and the State exchanged numerous comments and responses about the language and intent of the amendment. CMS Ex. 3 at 00243-00253. CMS thereafter approved the amendment after Alaska provided revisions based on those communications.

In September 2005, Alaska entered into two written "Disproportionate Share Hospital Payment Agreement[s] for Mental Health Clinic Assistance" for the 2006 state fiscal year. Ak. Exs. 22-23. One of the agreements was with a public hospital, Bartlett Regional Hospital, and the second was with a private hospital, Fairbanks Memorial Hospital. Id. The agreements required the hospitals to: 1) place the DSH payments they received from the State into designated disbursement accounts approved by the State; 2) retain interest earned on the funds in the accounts, and make it available for disbursement according to State directive; 3) pay "community service providers" pursuant to a listing of payments to those providers furnished by the State; and 4) report payments made under the agreement to the State "in a format prescribed by the [State]." Id. The agreements provided that the hospitals would retain five percent of the DSH payments "for administering" the agreements. Id. The balance was "for payments to qualified community service providers and shall be returned to the Department upon request if not otherwise authorized for disbursement. . . ." Id.

On May 31, 2006, CMS issued a notice of disallowance in the amount of $3,774,116 FFP for the quarter ending September 30, 2005. CMS wrote that the expenditures claimed as DSH payments were not authorized or allowable because the funds were redirected to entities other than DSH providers pursuant to contracts between the State and the two recipient hospitals. Ak. Ex. 27. CMS found that the payments were not allowable under sections 1902(a), 1903(a) and 1905(b) of the Act because they were not expenditures for covered medical assistance services. Further, CMS determined that the payments were inconsistent with section 1902(a)(19) of the Act because they were used to pay for non-inpatient services furnished by non-hospital providers; consequently, CMS concluded they did not serve the best interest

of Medicaid recipients. Id. In addition, CMS determined that because the State requires the funds to be "redirected to non-hospital providers," the payments remained under Alaska's "administrative control" and did not represent "net expenditures" of the State within the meaning of section 1903(a)(1) of the Act. Id.

Analysis

For the reasons discussed below, we sustain CMS's disallowances.

1. Alaska's claims for FFP for Private Proshare payments are not allowable under the approved State plan.

The central question presented by Alaska's claims for FFP associated with the Private Proshare payments is whether the payments, controlled by the written agreements between the State and Providence Hospital, were authorized under Alaska's approved State plan provision governing supplemental payments not exceeding the UPLs for private hospitals. Accordingly, we start our analysis with the requirements of Alaska's State plan.

In evaluating whether a state has followed its approved State plan, the Board first examines the language of the plan itself. South Dakota Dept. of Social Services, DAB No. 934, at 4 (1988); see also, Missouri Dept. of Social Services, DAB No. 1412 (1993); Colorado Dept. of Health Care and Policy Financing, DAB No. 2057 (2006). If the wording is clear, then the plain language of the provision will control. If, however, 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. Id. The Board will also consider the intent of the provision. Id. A state's interpretation cannot prevail unless it is reasonable in light of the purpose of the provision and program requirements, including governing federal law and regulations. Id.

The provision in Alaska's State plan addressing Private Proshare payments falls under the section of the State plan governing provider reimbursement for inpatient services. The introduction to that section reads:

> Inpatient hospital services . . . are paid **for Medicaid recipients** by means of rates determined in accordance with the following principles, methods and standards which comply with [42 CFR 447.250 THROUGH 477.299] 1902(a)(13)(A), 1902(a)(30), and 1923 of the Social Security Act and Federal regulations at 42 CFR 447.250

> through .252, .256, .257, .272, .280, and .296 through .299.

Ak. Ex. 28, at 1 (emphasis added). The State plan further states that "[a]llowable costs are those which **directly relate to Title XIX program recipients**." Id. at 2 (emphasis added). Thus, the State plan incorporates by reference the federal Medicaid statutes and regulations governing payment for inpatient hospital services, including the UPL provisions. Further, it explicitly requires that to be allowable, the services must relate directly to Medicaid recipients.

Section XV of Alaska's State plan, addressing Private Proshare payments, states that "[t]he private hospital facility-specific differences between [the facility's] UPL and estimated Medicaid payments are added together to calculate the statewide total for additional payments to all privately owned hospitals **for inpatient services."** Id. at 26 (emphasis added).

The approved Private Proshare amendment further states at subsection XV.3, that to be "qualified" to receive Proshare payments, a private hospital must, among other things, "enter[] into a written agreement with [Alaska's Department of Health and Social Services] **to provide** additional services under Section XV-6 . . . ." Id. at 25 (emphasis added). Section XV.6, in turn, reads:

> The department will allocate the PHPS funding it determines is available to the classifications of PHPS listed below:
>
> a) Single-Point-Of-Entry Psychiatric (SPEP PHPS);
> b) Designated Evaluation and Treatment (DET PHPS);
> c) Children's Medical Care (CMC PHPS);
> d) Institutional Community Health Care (ICHC PHPS);
> e) Rural Hospital Assistance (RHA PHPS);
> f) Rural Health Clinic Assistance (RHCA PHPS);
> g) Mental Health Clinic Assistance (MHCA PHPS); and
> h) Substance Abuse Treatment Provider (SATP PHPS).

Id. at 26. The State plan further reads:

> Distribution of Private Hospital Proportionate Share payments among qualifying private hospitals will occur within each classification listed in section 6, and is based on the number of prospective encounters the hospital **agrees to perform** under its PHPS agreement with the Department, as a percentage of all encounters **to be**

> **performed by all qualifying hospitals** within the classification.

Id. (emphasis added). The final paragraph in the State plan governing Private Proshare payments states:

> Qualifying hospitals receive proportionate share payments under one or more of the classifications listed in section 6, if that hospital meets criteria applicable to that classification by entering into a written agreement with the Department.

Id. Accordingly, the plain language of the State plan establishes that *to qualify* to receive supplemental Proshare payments, a private hospital must itself "provide" and "perform" one or more of the types of services listed at section XV.6 pursuant to a written agreement with the State. The State will then distribute the supplemental payments for inpatient services "among qualifying private hospitals" based on the number of "encounters" each hospital within each classification will itself "perform" or carry out. Nothing in the text of the provision authorizes the State to transmit a Proshare payment to a private hospital and then, under an agreement between the State and the hospital, require the hospital to disburse the funds to community service providers in support of non-Medicaid programs.

Applying the foregoing analysis to the record before us, we conclude that Alaska's claims relating to the 2005 and 2006 Proportionate Share Payment Agreements between the State and Providence Hospital are inconsistent with the State plan and the applicable Medicaid statutes and regulations.

Section one of the agreements, "Purpose and Scope," states that the purpose of the contracts is to "ensure continued access and reduce hospitalizations" by using Private Proshare payments to "fund[] services administered by qualified community service providers." Ak. Exs. 17-21, 29-34. Those services include children's medical care services, mental health clinic assistance services, rural health clinic assistance services, and single point of entry psychiatric services. Id. Thus, at the outset, the written agreements impermissibly divert the supplemental payments that the plan and Act require to be used to reimburse hospitals for covered inpatient services into funding for a variety of unauthorized "community service provider costs." Payments pursuant to the agreements therefore not only do not relate directly to Medicaid recipients, but also are not eligible for FFP because they do not represent amounts "expended . . . as

medical assistance" under sections 1903(a)(1) and 1905(a) of the Act.

Indeed, the record shows that the State made the Private Proshare payments in connection with a systematic plan to use Medicaid supplemental and DSH payments as "refinancing" mechanisms to fund non-Medicaid State grants to social services organizations. CMS Exs. 8, 9. For example, minutes of a 2003 meeting of the Alaska Council of Emergency Medical Services attribute the following remarks to Alaska Officials:

> Proshare is a new state program for financing payments to grantees. Reductions in the general fund monies available really threaten grant programs. It is not desirable to reduce clients or field staff, or dollar awards to grantees. The answer is this payment plan. Payments go to a private hospital after a negotiated agreement is signed. The purpose is to close the funding gap by maximizing Medicaid . . . . Commissioner [of Alaska's Department of Health and Social Services] Gilbertson came in, and he said this program permits savings through Medicaid. We do take some risks here, but the general fund was in trouble, and this arrangement assumes the dollars go to healthcare.

CMS. Ex. 9 (Minutes of Alaska Council on Emergency Medical Services Meeting, April 17, 2003). Likewise, minutes of an Alaska Medical Care Advisory Committee meeting that took place in February 2004, attribute to Commissioner Gilbertson the following additional statements:

> The goal in FY 04 was to refinance DHSS activities and Medicaid so that the federal government is supplanting state government expenditures. This refinancing was used to avoid reducing Medicaid eligibility, cutting rates and cutting optional services.
>
> . . . We must contain costs and restrain areas of exponential growth. . . . Initiatives that are moving forward include: . . . Refinancing - private pro-share strategies will continue. This involves having facilities use Medicaid funds to support mostly behavioral health grants formerly issued by the State with general fund dollars.

CMS. Ex. 9 (Medical Care Advisory Committee Draft Summary Minutes, February 20-21, 2004). Even Alaska concedes in this appeal that the payments financed non-hospital services that, at

least in part, were furnished to non-Medicaid recipients. See, e.g., Ak. Response to CMS Surreply at 1; Ak. Br. at 35-36; Ak. Ex. 11.[5] Hence, like the programs created by states to enhance their federal funding before the 2001 revision of the UPL regulations, Alaska's Private Proshare financing plan, which sought to replace State funding with increased FFP, was inconsistent with section 1902(a)(30) of the Act and violated the basic integrity of Medicaid as a joint, cooperative, federal-state program.

Further, in all but two of the agreements, the Private Proshare agreements required the hospital to distribute the Proshare monies to "qualified community service provider(s)" identified by the State, with the hospital retaining only a limited percentage of the funds as an "administrative fee."[6] Ak. Exs. 17-20, 29-33. Under these agreements, the hospital was required to notify the State if any interest was accrued on the funds and if any funds were unspent, and to "[k]eep accurate books or accounts and furnish the [State] with a prompt report of each payment." Id. Yet it was the State's responsibility under the agreements to identify the "qualified community providers," determine the

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[5] In June 2004, Alaska responded to CMS's question, whether the services provided by qualified community service providers were covered by the State plan and provided to Medicaid eligible individuals. Ak. Ex. 11. Alaska wrote that the State plan "may cover these services" and that "services may be provided to Medicaid eligibles." Id. Alaska has also submitted that approximately 90 percent of the community service providers were Medicaid-enrolled providers in 2006. Ak. Att. A ¶ 14. It is logical to presume, however, that if the services at issue here were otherwise eligible for FFP as approved "medical assistance" under the State plan, the providers would have sought payment for them accordingly, and the State would have claimed these costs separately. Further, since the history of Alaska's Private Proshare program shows the payment mechanism was designed to substitute federal funds for costs previously borne by the State, it is reasonable to assume that the services at issue here were not otherwise covered Medicaid services, provided to Medicaid eligible individuals.

[6] The July 13, 2005 and July 7, 2006 proportionate share payment agreements between Providence Hospital and Alaska establish that the Hospital itself would "perform the following: Provide Single Point of Entry hospital services to Medicaid recipients through its facilities." Ak. Exs. 21, 34 (Section Four, Statement of Work).

"amount approved for payment of work, and be "solely responsible" for monitoring the community service providers' actions relating to the agreement. Ak. Exs. 17-20. Thus, these agreements were inconsistent with the plain wording of the State plan that conditioned a private hospital's receipt of a supplemental Proshare payment on the hospital providing or performing the services itself.

Alaska argues that the State plan "expressly authorizes" the supplemental payments to be used to pay for the services set forth in the Private Proshare agreements. Specifically, the State asserts that section XV.6 of the approved amendment lists eight categories of such services, which include non-inpatient hospital services. In addition, Alaska submits that once a hospital qualifies to receive a supplemental payment under the UPLs, "there is no limitation on how a hospital may *use* the payments it receives" even though the payments "represent reimbursement for medical assistance as defined by the state." Ak. Response Br. at 2; Ak. Response to CMS Surreply at 3.

We disagree. The eight classifications of services are listed in the plan as services a hospital may provide to *qualify* to receive a Proshare payment. They are not listed as services to be financed by the Proshare payment. Moreover, the reference to the number of encounters the hospital would agree to provide is in the context of the methodology for how the available amount under the UPLs would be distributed among qualifying hospitals, as supplemental payments for inpatient hospital services. While the approved State plan permits Alaska to recognize and provide incentives to hospitals to "provide basic support for community and regional health care" by conditioning a hospital's receipt of a supplemental payment on the hospital furnishing such services, neither the plan's language nor the federal regulations permit Medicaid funds to be diverted to pay for non-institutional, non-Medicaid costs. To the contrary, as CMS stated in the preamble to the final rule revising the UPL regulations, to claim FFP in connection with supplemental payments for hospital inpatient services and then have the recipient institutions transfer the federal funds to support some alternative program "completely undermine[s] the integrity of the Medicaid program." 66 Fed. Reg. at 3167. As CMS also stated in the preamble, published well before Alaska submitted and received approval for the revised State plan amendment, it was the agency's intent under the revised regulations to ensure that Medicaid payments to inpatient institutional providers would be "retained by those facilities to

offset the costs they incurred in furnishing Medicaid services to eligible individuals."[7] Id.

Here, the payments were not made to and retained by the hospital to offset the costs of providing inpatient hospital services. Rather the funds were passed through the hospital and disbursed to non-hospital entities to pay for services that included those not allowed under the Medicaid program and not furnished to Medicaid recipients. The funds were used, at least in part, to make up for shortfalls in the State's general fund to finance other State grant programs. CMS Exs. 8-9. The hospital retained only limited amounts of the payments as "administrative fees," representing compensation for disbursing the funds as dictated by the State, keeping records of the disbursements, and reporting the disbursements to the State. Thus, the diversion of the payments was inconsistent with sections 1902(a)(19) and 1902(a)(30)(A) of the Act, incorporated by reference into Alaska's State plan, which require that under the State plan, covered Medicaid "care and services will be provided in a manner consistent with simplicity of administration and the best interest of [Medicaid] recipients" and that payments for covered services "are consistent with efficiency, economy, and quality of care" under the Medicaid program.

That the hospital voluntarily entered into these agreements which, according to the State, reduced the burden on the hospital to provide inpatient services to individuals better served at the community level, does not mean that the conditions the agreements imposed on the use of the funds were appropriate under the State plan and federal requirements. Indeed, the conditions transformed the payments into something other than "expenditures for medical assistance" pursuant to the State plan. Accordingly,

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[7] On May 29, 2007, CMS published a new rule at 42 C.F.R. § 447.207 addressing retention of Medicaid payments by providers. 72 Fed. Reg. 29,748, 29,834 (May 29, 2007). Under the new rule, "[p]ayment methodologies must permit the provider to receive and retain the full amount of the total computable payment for services furnished under the approved State plan," except that FFP may be used to fund a provider's "normal operating expenses of conducting business." Id. Alaska argues that the new rule shows that there was no payment retention requirement in effect during the period at issue here. We disagree. The preamble to the final UPL rule published in 2001 made clear that CMS interpreted the existing title XIX provisions to preclude FFP in claims like those relating to the underlying agreements in this case.

even if one found ambiguity in the language of the State plan, we conclude that interpreting the State plan to permit payments conditioned as the agreements conditioned these payments would be unreasonable because it squarely contravenes fundamental Medicaid principles. In our view, these payments were not amounts expended "for medical assistance" under any reasonable reading of that language. Instead, the funds remained under the administrative control of the state, and were expended for other purposes.

Moreover, Alaska had timely and adequate notice, from the statements in the preamble to the January 12, 2001 rule revising the UPL regulations that these claims would not be allowable. The preamble made clear that CMS read the federal requirements to prohibit FFP when, as here, states "represent expenditures for the medically necessary provision [of] institutional care for the purpose of claiming Federal matching funds, and then have those institutions transfer Federal funds to support non-institutional services . . . to support some type of alternative program." 66 Fed. Reg. at 3167.

We do agree with Alaska that a hospital is not always required to apply all of the funds it receives as reimbursement for inpatient hospital services for other inpatient hospital services. If, for example, a hospital has applied non-Medicaid funds to cover the costs of services to Medicaid recipients and is entitled to additional retrospective payments under a State plan for those services, the additional funds become the hospital's funds to disburse for whatever purposes are consistent with its governing polices. Here, however, the payments were not treated as payments to the hospitals to reimburse costs associated with furnishing inpatient services to Medicaid recipients. Rather, as detailed above, the written agreements between the State and Providence Hospital treated the amounts paid to the hospitals as funds to be disbursed according to State directives or as an administrative fee, not as payments to the hospital to offset the costs incurred by the hospital in providing inpatient hospital services.

We also note that the context of the provisions at issue — providing for payment of inpatient hospital services – does not necessarily preclude a State plan provision requiring a hospital to perform services that are not themselves inpatient hospital services in order to qualify for, or as a condition to receipt of, a supplemental payment. Indeed, under Alaska's State plan, a hospital could qualify to receive supplemental payments for inpatient hospital services by performing rural health clinic assistance services, mental health clinic assistance services, or

other services. In the context of determining the amount to pay a hospital for inpatient hospital services, however, such provisions cannot reasonably be read to permit the State to dictate how the funds will be used, once paid to a qualifying hospital. Nor does CMS's approval of such a provision mean that CMS must accept payments that are clearly made for another, non-Medicaid purpose as amounts "expended as medical assistance" for inpatient hospital services.

Alaska further contends that the language of the State plan amendment was flexible enough to allow the hospital to "support" the services listed at section XV.6 of the State plan by "paying community-based providers to provide them" based on the voluntary agreements between the State and the hospital. Ak. Response to CMS Surreply at 1,3. Alaska also contends that the hospital's use of arrangements with the other entities was efficient. The State further submits that nothing in the plan limits the performance of the qualifying services to the hospital and that the differences between the hospital performing the services and another organization performing the services is insignificant.

We disagree. While a provider of services may in some circumstances provide services "under arrangement" with another organization, in this case the State plan's use of the word "performs" required the hospital itself to furnish the qualifying services. Further, even if the State plan could be construed as permitting the hospital to provide the qualifying services under arrangements with other entities, the agreements here were agreements between Alaska and the private hospitals, not arrangements between the hospital and the community-based service providers. Moreover, while Alaska represented to CMS that under the agreements, a hospital could "choose to arrange with local community providers to perform certain services for which [the hospitals] are paid through their distribution of the PHPS payments," the record does not show that the hospitals exercised any choice in determining who would perform the services, how the services would be provided, or how much money would be paid for the services. Ak Ex. 11. Rather, on their faces the written agreements specify that the hospitals are not taking any responsibility for the community-based services and that monitoring the quality and amount of the services performed is the State's responsibility.

In sum, Alaska should have known that the agreements to disburse funds to specified community-based organizations designated by the State with an amount to be retained by the hospitals as an "administrative fee" would be seen for what they were – a mechanism for obtaining federal Medicaid funds and using them for

purposes inconsistent with the purposes for which Congress appropriated those funds. The agreements show that the payments were never intended to be reimbursement to the hospitals for the inpatient hospital services they provided to Medicaid recipients but instead were intended to fund, at least in part, non-Medicaid covered services provided by community-based organizations to non-Medicaid recipients. That those funds may have, in a broad sense, been of some benefit to the Medicaid program is irrelevant because Alaska could not reasonably have thought they could be considered amounts "expended as medical assistance" under the inpatient hospital services provision of the State plan.

Accordingly, we reject the State's interpretation of its State plan as authorizing FFP in connection with the Private Proshare payments and sustain CMS's disallowances.

2. Alaska's claims for FFP relating to DSH payments are not allowable because they are inconsistent with the approved State plan.

The second question presented in Alaska's appeal is whether the State's claims for FFP associated with the payments Alaska made pursuant to the September 2005 written DSH payment agreements with Bartlett Regional Hospital and Fairbanks Memorial Hospital were consistent with Alaska's approved State plan. Again applying the standard for evaluating whether a state has followed its approved state plan, we look first to the language of the relevant provision.

The applicable section of Alaska's State Plan governing "hospitals serving a disproportionate share of low income patients," at Section XI, states that DSH payments are based on the requirements of sections 1902(a)(13)(A) and 1923(a)(1) of the Act, which take into account the "situation" of DSH providers by "making a payment adjustment **for qualifying hospitals**." Ak. Ex. 28, at 12 (emphasis added). The State Plan also provides that DSH hospitals "**will receive a payment adjustment** based on the . . . criteria and methods [set forth in the State Plan]." Id. (emphasis added). The provision further states that Alaska "intends to make DSH payments **to facilities** . . . **in response to their respective service** to low-income patients with special needs." Id. (emphasis added). Thus, the State plan incorporates sections 1923 and 1902(a)(13)(A)(iv) of the Act, requiring DSH payments to be used to help inpatient facilities that have high volumes of Medicaid recipients and uninsured patients by providing payment adjustments to offset the hospitals' operating losses associated with providing care to those patients. Nothing

in the State plan's DSH provision indicates that once a DSH hospital receives its payment adjustment, it will disburse the funds to other entities as directed by the State to support non-Medicaid programs.

The State plan further sets forth a series of "classifications" under which a hospital may qualify for, or be eligible to receive, a DSH payment adjustment. Id. These classifications include "Mental Health Clinic Assistance Disproportionate Share Hospital." Id. Later, the plan states that a mental health clinic assistance disproportionate share hospital, or "MHCA DSH," "may qualify" to receive a DSH payment "if it enters into an agreement with the department under which it **agrees to report the number of MHCA encounters** for use in determining the appropriate distribution of MHCA DSH funds among all hospitals that qualify for MHCA DSH payment." Id. at 15 (emphasis added). Subsection (2) of the provision, in turn, addresses the distribution of DSH payments:

> (2) Distribution of DSH Payments. DSH **payments will be distributed to qualified hospitals** according to the following methods.
>
> . . .
>
> (c) Encounter Based Classification Payments. **Each disproportionate share payment** for the . . . MHCA DSH . . . classification() will be calculated within each classification **based on the number of encounters to be performed by the qualifying hospital for that classification . . . divided by the total number of encounters to be performed by all qualifying hospitals within that classification . . . .**

Id. at 15-17(emphasis added). The State plan defines an "encounter" as a "unit of service, visit, or face-to-face contact that is a covered service . . . ." Id. at 19.

Thus, under the plain language of the provision, Alaska may direct payment adjustments to DSH hospitals that qualify to receive the funds by providing mental health clinic assistance services. The provision also sets forth a methodology for allocating DSH funds among qualifying MHCA DSH hospitals based on the numbers of services "performed by" the recipient DSH hospital. Like the State plan's Private Proshare provision, the DSH provision indicates that the recipient hospital itself will

provide or perform the qualifying services; nothing in the plan indicates that the services will be performed by other entities. Further, the language of the plan makes clear that the number of encounters a DSH hospital provides serves as a basis for determining how Alaska will distribute DSH funds to qualifying hospitals. The provision does not, however, establish that a DSH payment adjustment is intended to be used to offset or reimburse the provider for the costs of performing MHCA services themselves.

Indeed, the last sentence of the DSH payment classifications section states that an MHCA DSH is an "agreement to provide services through freestanding clinics" and "[its] costs are **not** included in the hospital facility specific limit for DSH payments." Id. at 13 (emphasis added). Section (3) of the provision, addressing payment limits, reads: "The total annual disproportionate share payment for each qualifying hospital is subject to a facility-specific limit (FSL) calculated for the hospital's qualifying year." Id. at 17. Notably, the last sentence of the DSH payment classifications section was added after CMS notified Alaska that the amendment adding substance abuse and mental health clinic services to the DSH provision would not be approved unless Alaska made assurances that "clinic costs of any kind" would not be included in the calculation of a hospital-specific limit because such costs are not "hospital costs" under the DSH statute. CMS Ex. 3, at 00243-00249.

The language of the State plan thereby establishes that while a hospital may qualify to receive a DSH payment by providing MHCA services through freestanding clinics, the costs of providing such services themselves may not be included in the calculation of the hospital specific limit and, consequently, are not intended to be offset or reimbursed by the DSH payment adjustment. By excluding the costs of providing the qualifying MHCA services from a hospital's DSH limit, the State plan thereby implements section 1923(g)(1)(A) of the Act, as reflected in the legislative history of the 1993 amendment, which requires DSH payment adjustments to be used to offset each hospital's DSH-related expenses, and not to be used to replace other costs.

Applying Section XI of Alaska's State plan to the record, we conclude that Alaska's DSH payment adjustment claims relating to the September 2005 written agreements between the State and Bartlett Regional Hospital and between the State and Fairbanks Memorial Hospital, were not authorized by the approved State plan and contravene the Medicaid Statute. Like the Private Proshare agreements, the DSH Payment agreements for Mental Health Clinic Assistance with Bartlett Regional Hospital and Fairbanks Memorial

Hospital required the hospitals to: 1) place the payments received from the State into "designated disbursement" accounts, approved by the State; 2) retain any interest earned on the funds in the designated disbursement accounts and make the interest available for disbursement according to State directives; 3) distribute the DSH incentive payments received from the State to "qualified community service provider(s)" identified by the State, with the hospital retaining only a limited percentage of the funds as an "administrative fee"; and 4) report to the State the payments made, in a "format prescribed by the [State]." Under the agreements, it was the State's responsibility to identify the "qualified community service providers," determine the "amount approved for payment of work," and be "solely responsible" for monitoring the community service providers' actions relating to the agreement. Ak. Exs. 22-23.

By the express terms of the written agreements, the State used Bartlett Regional Hospital and Fairbanks Memorial Hospital to divert funds intended to offset the operating costs of the DSH hospitals associated with serving a disproportionate share of Medicaid recipients and uninsured persons to pay for unauthorized services. The payment adjustments were not received and retained by the hospitals but were effectively passed through the DSH providers and, at the State's directive, disbursed to non-hospital entities. The DSH hospitals retained only limited funds, not to offset their DSH-related costs, but as administrative fees for disbursing the funds at the State's directives. Thus, the payments were not authorized by the State plan which, implementing sections 1902(a)(13)(A)(iv) and 1923(a)(1) of the Act, required the DSH payment adjustments to go "to [DSH] facilities . . . in response to their respective service to low income patients with special needs." Ak. Ex. 28.

Like the Private Proshare payments, the supplemental DSH payments made in connection with the written agreements were impermissibly used to pay a variety of non-Medicaid community service provider costs. Thus, like the Private Proshare payments, the DSH payments did not relate directly to Medicaid recipients, as required by the State plan, and were not eligible for FFP because they did not represent amounts "expended . . . as medical assistance" as required under sections 1903(a)(1) and 1905(a) of the Act. Moreover, like the Private Proshare payments, the payments Alaska made pursuant to the DSH agreements violated the State plan requirements under sections 1902(a)(19) and 1902(a)(30)(A) of the Act, that payments to assure that covered "care and services . . . be provided in a manner consistent with simplicity of administration and the best interest of [Medicaid] recipients" and assure that "payments are consistent with

efficiency, economy and quality of care." In sum, diverting DSH funds to non-Medicaid providers to support alternative programs does not serve the best interest of Medicaid recipients or reflect the efficient and economical use of program funds.

Alaska argues that the State plan authorized the payments relating to the agreements with Bartlett Regional Hospital and Fairbanks Memorial Hospital because the plan specifically states that payments may be made to hospitals that provide community-based services and that MHCA encounters are to be provided through freestanding clinics. In addition, Alaska argues, nothing in the plan precludes a hospital from "us[ing] the funds to arrange for the provision of community-based services" furnished by non-hospital entities. Alaska also submits that the language in the State plan requiring the clinics' costs to be excluded from the hospital-specific limit for DSH payments refers to the method of calculating the level of DSH funds Alaska will receive, not to how DSH payments may be used.

We disagree. As discussed above, while the State plan and Medicaid statutes permit Alaska to condition a DSH hospital's receipt of a payment adjustment based on the hospital providing certain community-based services, the DSH adjustment is not intended to pay for those services, but to reimburse the hospital for otherwise unreimbursed DSH-related costs. Indeed, as we discussed above, CMS required specific language to be added to Alaska's DSH State plan amendment to the effect that the costs of the MHCA services would not be included in calculating a hospital-specific limit because these funds were not intended to be offset or reimbursed by the DSH payment adjustment. The funds paid in connection with the written agreements with Bartlett Regional and Fairbanks Memorial hospitals were not retained by the hospitals to offset their DSH costs, but were passed through the hospitals and, at the State's direction, disbursed to other entities to fund non-Medicaid costs. Hence, they were not authorized by the State plan or Medicaid statute, and Alaska's interpretation of its State plan must be rejected.

Further, as we stated in connection with the Private Proshare claims, even if a provider of services in some cases may provide services "under arrangements" with other entities, here the State plan's use of the word "performs" required the hospital itself to carry out the qualifying MHCA services. Moreover, even if one read the State plan as allowing the hospital to provide the services under arrangements with other entities, the agreements here were not such arrangements. Rather, the written agreements specified that the State itself would be identifying, monitoring, and determining the amount of the payments due to the various

community service providers. The hospitals acted merely as conduits for the payments, retaining limited fees as compensation for the administrative costs of disbursing the funds and reporting the disbursements to the State.

In sum, like the agreements underlying Alaska's Private Proshare claims, the DSH payment agreements show that the State did not intend to use claimed DSH funding as reimbursement to DSH hospitals for uncompensated costs relating to providing services to Medicaid recipients and uninsured persons, but to fund alternative services. That the services may have indirectly benefitted the goals of the Medicaid program by "promot[ing] the overall health of Alaska residents" is irrelevant. Ak. Br. at 30. Like the state financing practices that used federal DSH funding to replace expenditures that the states were obliged to incur apart from providing Medicaid services that the 1993 DSH facility-specific limit amendment was intended to prevent, Alaska's attempt here to divert DSH funds to support other State programs would undermine the fundamental purpose of the DSH statutes.

Accordingly, we reject Alaska's interpretation of the State plan to authorize these claims as unreasonable and uphold CMS's disallowances relating to the DSH payment agreements.

III. CMS properly used the disallowance process in this case.

Alaska contends that CMS improperly used the disallowance process in this dispute. The State asserts that CMS, in effect, is attempting to undo its prior approval of the State Plan amendments that authorize the supplemental and DSH payments by using inapplicable procedures. Before CMS issued the disallowance notices, Alaska contends, CMS understood Alaska's State Plan to allow the State to claim FFP for the contested Proshare and DSH payments. Alaska argues that CMS "changed its mind about approval of the State Plan amendment" and attempted to revoke its prior approval by issuing disallowances of authorized claims. App. Br. at 31. CMS, Alaska contends, should have treated this as a compliance matter and taken steps under section 1904 of the Act and 42 C.F.R. § 430.35, including providing the State with reasonable notice and an opportunity for a hearing, to determine if either the State "plan has been so changed that it no longer complies with the provisions of section 1902 of the Act" or if "in the administration of the plan there [was] a failure to comply substantially with any such provision."

The Board has thoroughly analyzed the question whether particular agency actions should be considered compliance matters or disallowance matters in numerous prior decisions. See, e.g., California Dept. of Health Services, DAB No. 1490 (1994); New Jersey Dept. of Human Services, DAB No. 259 (1982); New York State Dept. of Social Services, DAB No. 1246 (1991); and Colorado Dept. of Social Services, DAB No. 1277 (1991), aff'd, Colorado Dep't of Social Services v. HHS, No. 92-F-653 (D. Colo. July 17, 1992). In those decisions, the Board observed that a compliance action "arises from a finding that a state is in substantial noncompliance with program requirements, leading to a **prospective** withholding of part or all funding to the state in order to give it compelling incentive to bring its program back into compliance." DAB 1490, at 6 (emphasis added). Withholding continues until CMS is satisfied that the State's plan and practice are, and will continue to be, in compliance with federal requirements. 42 C.F.R. § 430.35(d)(1)(ii).

Separate from compliance actions, when CMS "determines that a claim or portion of a claim is not allowable," CMS will issue a notice of a disallowance, which is subject to a reconsideration by the Board under 1116(d) of the Act and 42 C.F.R. § 430.42. A disallowance is retrospective in nature. Through the disallowance process, claims for a prior period are denied, or, if already paid, recouped. Thus, the Board has noted, a disallowance determination on a claim for FFP is "retrospective and limited in nature, with an agency seeking the recovery of discrete sums which have been previously paid to a state or claimed by a state in excess of the amount to which the state was entitled." DAB No. 1490, at 6. Further, a disallowance determination "provides a specific and focused remedy" relating to a precise amount of unallowable claims for a specified period of time. Id. The Board has also observed that "[a]n agency sometimes has the choice of instituting a compliance action or taking a disallowance, or both." Id. at 7.

In this case CMS's determinations to disallow FFP claims associated with the Private Proshare and DSH payment written agreements were retrospective in nature, limited to specific claims for discrete prior time periods. Further, CMS's determinations related only to particular types of claims – those seeking FFP for Proshare and DSH payments relating to written agreements between the State and several hospitals – that CMS found inconsistent with Alaska's approved State Plan. Accordingly, we conclude that CMS properly issued disallowance determinations and followed the disallowance process at section 1116(d) of the Act and 42 C.F.R. § 430.42.

Further, we disagree with the premise of Alaska's argument, that in issuing the disallowance determinations, CMS was attempting to undo its prior approval of the amendments because CMS recognized that the amendments authorized the Proshare and DSH payments. The record shows that CMS became aware of the exact nature of the Private Proshare and DSH agreements, the use of FFP claimed in connection with the agreements to support non-Medicaid programs, and Alaska's interpretation of its State plan to permit this diversion of Medicaid funds, only after Alaska submitted its first FFP claims relating to the Proshare and DSH agreements for the quarter ending September 30, 2003. CMS's February 11, 2004 notice to the State that the first claims would be deferred, and subsequent communications between CMS and Alaska, show that once CMS became fully aware of the underlying transactions, it questioned them. In none of these documents did CMS state that the claims were consistent with the State plan or communicate that it wished to revoke its prior approvals of the amendments. To the contrary, CMS's deferral notice of February 11, 2004, relating to Alaska's first Private Proshare claims, specifically stated that the inquiry process will in part address "inconsistencies with SPA TN 02-005 [the Proshare amendment]" and the State's claims. CMS Ex. 10 at 1. Further, after Alaska provided CMS copies of the written Proshare and DSH agreements, CMS asked the State "how the expenditures related to these agreements are in compliance with the approved State Plan?" Ak. Ex. 10. In sum, once CMS became fully apprised of how the State intended to use the Private Proshare and DSH federal funding, it became evident not only that Alaska had failed to provide the full details of its planned use of the Private Proshare and DSH funds during the State Plan amendment process, but also that the State's interpretation of its State plan did not square with the actual language of the approved amendments or the governing requirements of the Medicaid statute and regulations.

Alaska suggests that CMS's decision to pay similar claims for FFP for earlier periods and its understanding that the State would voluntarily change the State plan show that CMS understood that the State plan authorized the claims. We disagree. The record shows that CMS paid the earlier Proshare claims based on its understanding that the State had agreed to work cooperatively to end the State's practice of diverting Proshare funds for unallowable purposes, not because CMS construed the amended State Plan as authorizing the payments. As reflected in the October 8, 2004 letter from Secretary Thompson to Governor Murkowski, the Secretary agreed to release the deferred FFP for the initial claims and pay for like claims through State fiscal year 2005, in exchange for the State's "cooperation and willingness to develop

alternative financing of these hospital payments effective July 1, 2005." Ak. Ex. 12.

Alaska argues that the wording in Secretary Thompson's October 2004 letter is so vague and confusing that it "made no sense to [Alaska's] staff," that the State never agreed to the alleged compromise, and that the meeting between the Governor and Secretary did not involve the Private Proshare Problem. Ak. Br. at 14. In spite of the ambiguities of the letter, and regardless of whether the State did or did not agree to the alleged compromise, the letter from the Secretary evidences that the decision to release the deferred FFP and permit the State to make limited additional Private Proshare claims was not based on the Secretary or CMS reaching the conclusion that the claims were allowable under the State plan. Rather, the letter shows that the Secretary directed CMS to release the FFP and expected Alaska to submit changes to the State plan which had been subject to Alaska's misinterpretation because he believed the State intended to work cooperatively "to preserve the fiscal integrity of the Medicaid program" and to make changes "to ensure the funds are used to serve individuals in the Medicaid program." Ak. Ex. 12. That a plan amendment may have been an expected part of *ensuring* that these goals were met does not mean that CMS or the Secretary had conceded that Alaska's interpretation of its approved plan was a reasonable one, consistent with federal requirements.

In sum, we reject Alaska's contentions that CMS should have initiated a compliance action in this case and that CMS had, in effect, conceded that the State plan authorized the payments at issue.

Conclusion

For the reasons above, we affirm CMS's decision to disallow $42,263,333 in federal financial participation for the Private Proshare and DSH payments made by Alaska to Providence Hospital, Bartlett Regional Hospital and Fairbanks Memorial Hospital claimed for the period July 1, 2005 - September 30, 2006.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member