Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Virginia Department of Medical Assistance Services
Docket No. A-06-05
Decision No. 2084

DATE: May 18, 2007

DECISION

The Virginia Department of Medical Assistance Services (Virginia or State) appealed a disallowance of $11,085,181 issued by the Centers for Medicare & Medicaid Services (CMS). The disallowance concerns Virginia's Medicaid payments to two "disproportionate share hospitals" (DSHs).

The federal Medicaid statute, found in title XIX of the Social Security Act (Act),[1] requires state Medicaid programs to make special payments, known as DSH payments, to hospitals that serve unusually large numbers of Medicaid and other low-income patients. These payments supplement what the hospitals receive for covered medical services under a state's standard Medicaid rates. The federal government reimburses states for a percentage of their DSH payments.

Section 1923(g)(1)(A) of the Act imposes a cap or limit on the amount of DSH payments that may be made to a hospital during a fiscal year. This annual payment limit is equal to the hospital's uncompensated (unreimbursed) costs of furnishing "hospital services" to persons who are eligible for Medicaid or who have no health insurance (or other source of third party coverage).

An audit performed by the Department of Health and Human Services' Office of Inspector General (OIG) found that Virginia's two state-owned teaching hospitals had overstated their DSH

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[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.

payment limits for state fiscal years (SFYs) 1997 and 1998 by including the uncompensated costs of services furnished by physicians to indigent hospital patients. When those costs were removed from the payment limit calculations, the OIG found that Virginia's DSH payments to the teaching hospitals in SFYs 1997 and 1998 had exceeded the hospitals' (recalculated) payment limits for those years. Based on the OIG's audit findings, CMS issued the challenged disallowance, which demanded that Virginia refund the federal funds paid to Virginia for the allegedly excessive DSH payments in SFYs 1997 and 1998.

The central issue in this appeal is whether the uncompensated physician costs were properly included in the calculation of the teaching hospitals' annual DSH payment limit. Virginia insists that the physician costs met the statutory criteria for inclusion. CMS responds that the costs were properly excluded because they were not costs of "hospital services" within the meaning of section 1923(g)(1)(A).

An official 1994 interpretation of section 1923(g)(1)(A), announced in a letter to all state Medicaid directors, advised states that a cost could be included in the DSH payment limit calculation only if it was an "allowable" cost of an inpatient hospital or outpatient hospital service. We find that Virginia had adequate notice of this statutory interpretation prior to making the disallowed DSH payments and that the interpretation is a reasonable one. Furthermore, the physician costs at issue were not recognized by Virginia's Medicaid program as allowable costs of inpatient hospital or outpatient hospital services, nor could they have been considered allowable hospital costs under Medicare cost reimbursement principles. For these and other reasons, we affirm the disallowance.

Legal Background

Medicaid is a program in which states and the federal government share the cost of providing necessary medical care to financially needy and disabled persons. Act §§ 1901, 1903. Each state administers its own Medicaid program under broad federal requirements and the terms of its "plan for medical assistance" (state plan), which must be approved by the Secretary of Health and Human Services. Id. § 1902. The state plan must specify the medical items and services covered by the state's program. Act § 1902; 42 C.F.R. § 430.10. The plan must also establish the policies and methods used in setting payment rates for covered services. 42 C.F.R. § 447.201(b). Once the state plan is approved, a state becomes entitled to receive federal reimbursement, or "federal financial participation" (FFP), for a

percentage of its expenditures for "medical assistance" (covered medical care) under the state plan. Act §§ 1903(a)(1), 1905(a). The types or categories of reimbursable medical assistance include inpatient hospital services, outpatient hospital services, and physicians' services. Id. § 1905(a).

A state Medicaid program pays for hospital services on the basis of payment rates that the state determines in accordance with its state plan. Act § 1902(a)(13); 42 C.F.R. §§ 447.252(b). In paying for hospital services, states must "take into account . . . the situation of" DSHs, or "hospitals which serve a disproportionate number of low income patients with special needs." Act § 1902(a)(13)(A)(iv). This mandate reflects a congressional finding that "public hospitals and teaching hospitals which serve large Medicaid and low income populations 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. 97-208, at 962 (1981), reprinted in 1981 U.S.C.C.A.N. 1010, 1324.[2]

Section 1923 of the Act imposes specific payment obligations with respect to DSHs. In particular, it requires a state plan to provide for "an appropriate increase in the rate or amount of payment" for "inpatient hospital services" furnished by DSHs. Act § 1923(a)(1)(B). In other words, a state must supplement the payments that DSHs receive based on standard Medicaid payment rates for inpatient hospital services. Act § 1923(a)(1)(B). A state may choose one of three formulas for calculating DSH payments. Act § 1923(c).

In 1993, Congress enacted the Omnibus Budget Reconciliation Act of 1993 ("1993 OBRA"). The 1993 OBRA amended the Medicaid statute by adding section 1923(g), the provision at issue in this appeal. Pub. L. No. 103-66, 107 Stat. 312, 629-633.

According to a House Budget Committee Report on the 1993 OBRA, section 1923(g) was a response to concern that some states were

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[2] See also H.R. Rep. 100-391(I), at 524 (1987), reprinted in 1987 U.S.C.C.A.N. 2313, 2344 (indicating that the purpose of requiring DSH payments was to ensure 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").

making DSH payments that exceeded the hospitals' costs of providing medical care to the indigent.[3] To address that concern, section 1923(g)(1)(A) provides that DSH payments to a hospital in a given fiscal year may not exceed:

> the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

Act § 1923(g)(1)(A) (emphasis added). The House Conference Report on the 1993 OBRA states that section 1923(g) —

> [l]imits disproportionate share hospital (DSH) payment adjustments to no more than the costs of providing inpatient and outpatient services to Medicaid and

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[3] The impetus for section 1923(g) was described in the House Budget Committee report as follows:

> 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.

H.R. Rep. No. 103-111, at 211-12 (1993), reprinted in 1993 U.S.S.C.A.N. 278, 578-79.

> uninsured patients, less payments from Medicaid (other than DSH payment adjustments) and uninsured patients.

H.R. Conf. Rep. No. 103-213, at 835 (1993), reprinted in 1993 U.S.C.C.A.N. 1088, 1524 (emphasis added).

On August 17, 1994, CMS issued a letter, addressed to all state Medicaid directors, regarding the 1993 OBRA's DSH-related provisions. Va. Ex. 61. Attached to this state Medicaid director letter (SMDL) was a summary containing CMS's "interpretation of the key provisions of the new law," including section 1923(g)(1)(A). Id. (We will refer to the SMDL and the attached summary collectively as the "1994 SMDL.")

The 1994 SMDL states that section 1923(g)(1)(A) "establishes a limit on the amount of the payment adjustment [DSH payment] that may be made to any DSH during the State fiscal year," and that "[t]he annual DSH payment adjustment to each DSH may not exceed the limit for that hospital." Va. Ex. 61 (page 2 of summary). The 1994 SMDL further provides that the hospital-specific DSH payment limit is equal to the sum of: (1) the "cost of services" provided by the hospital to Medicaid patients "less the amount paid by the State under the non-DSH payment provisions of the State Plan"; and (2) the "Cost of Services to Uninsured Patients, less any cash payments made by them." Id. (page 3 of summary). In addition, the 1994 SMDL sets out the following principles for determining a hospital's uncompensated "cost of services":

> COST OF SERVICES
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> There are several important considerations that must be made in determining the cost of services under the DSH limit, whether for Medicaid or uninsured individuals. First, the legislative history of this provision makes it clear that States may include both inpatient and outpatient costs in the calculation of the limit. Second, in defining "costs of services" under this provision, [CMS] would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. The Medicare principles are the general upper payment limit under institutional payment under

> the Medicaid program.[4] [CMS] believes this interpretation of the term "costs incurred" is reasonable because it provides States with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs.

Id. (footnote added).

Although CMS indicated in the 1994 SMDL that it intended to publish regulations implementing section 1923(g), CMS has never done so.

Case Background

In early 2003, the OIG completed audits of Virginia's DSH payments to the University of Virginia Medical Center (UVMC) and the Medical College of Virginia Hospital (MCVH) for SFYs 1997 and 1998. UVMC and MCVH are state-owned teaching hospitals. Virginia Dept. of Medical Assistance Services, DAB No. 1838 (2002). MCVH is affiliated with Virginia Commonwealth University. Va. Exs. 7-8.

The OIG audits found that UVMC and MCVH had overstated their DSH payment limits for SFYs 1997 and 1998 by including the uncompensated costs of medical care that had been furnished directly to hospital patients by faculty physicians. Va. Ex. 2, at 3-4; Va. Ex. 3, at 3-4. According to the OIG, those costs were incurred not by the hospitals but by physician practice groups that were legally separate from the hospitals. In particular, the OIG found that the uncompensated physician costs included in the calculation of UVMC's DSH payment limits for SFYs 1997 and 1998 had been incurred by a "non-profit physician group practice organization" called the University of Virginia Health Services Foundation (HSF), whose members consisted "primarily of physician faculty employees" of the University of Virginia Health Sciences Center. Va. Ex. 2, at 4. In addition, the OIG found that the uncompensated physician costs included in the payment limit calculations for MCVH had been incurred by a physician

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[4] A Medicaid upper payment limit (UPL) caps the amount that a state may pay, in the aggregate, to a group of providers for certain categories of medical services and still receive federal matching funds. See, e.g., 42 C.F.R. §§ 447.257, 447.272. The UPL is a "reasonable estimate" of what would be (or would have been) paid for those services under "Medicare payment principles." 42 C.F.R. §§ 447.272(b)(1), 447.321(b)(1).

group composed of faculty of the Virginia Commonwealth University School of Medicine. Va. Ex. 3, at 3-4.

When the OIG recalculated the payment limits without the physician costs, it found that Virginia's DSH payments to the hospitals for SFYs 1997 and 1998 had (with one exception) exceeded the hospitals' recalculated payment limits for those years.[5] The OIG also found that Virginia had received $11,085,181 in FFP for the allegedly excessive DSH payments. Va. Ex. 2, at 7; Va. Ex. 3, at 10.

Based on the OIG's audit findings, CMS issued the disallowance that Virginia is now appealing. Va. Ex. 1. In a September 8, 2005 letter informing Virginia of the disallowance, CMS indicated that it concurred with the OIG's finding that the hospitals had overstated their DSH payment limits by including costs of "independent physician groups." Id. at 1-2. CMS stated that the groups' physicians were not hospital "employees" and that they "billed separately for their services and had their own Medicaid provider identification numbers." Id. In addition, CMS stated that the services rendered by the groups' physicians —

> were billed and paid by the State and other payers as physician services (or as services of other related practitioners) and not as hospital services. As such, the physician groups are separate entities and their costs should not have been included with the hospitals' uncompensated cost of furnishing hospital services.

Id. at 2. CMS concluded that, because the hospitals had overstated their uncompensated costs, Virginia's DSH payments in SFYs 1997 and 1998 exceeded the "amounts authorized in the approved State plan and limitations in section 1923(g) of the Act," and that the amount of federal reimbursement paid to Virginia for those excess payments — $11,085,191 — had to be refunded to the federal government. Id. at 2.

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[5] The OIG calculated that UVMC had received excess DSH payments totaling $10,302,524 for SFY 1997, and $8,814,198 for SFY 1998. Va. Ex. 2, at 7. In addition, the OIG calculated that MCVH had received $12,276,389 in excess DSH payments for SFY 1997. Va. Ex. 3, at 4, 10. The OIG found that MCVH received no excess DSH payments for SFY 1998. Id.

Discussion

The parties agree that the outcome of this appeal depends on the answer to the following question: were the physician costs at issue "costs incurred . . . of furnishing hospital services" under section 1923(g)(1)(A) and thus properly included in the calculation of the teaching hospitals' DSH payment limits for SFYs 1997 and 1998?

This question poses two issues. The first is whether the physician costs were "incurred" by the hospitals. The initial justification for the disallowance was that "independent physician groups," not the hospitals, had incurred the costs. Virginia disputes that conclusion, Va. Br. at 11-23, and CMS has made no attempt to defend it in this appeal. For that reason, we focus on the second issue, which is whether the costs were for "hospital services" under section 1923(g)(1)(A).

The starting point for resolving that issue is, of course, the statute's text. United States v. Turkette, 452 U.S. 576, 580 (1981). If that text clearly and precisely addresses the issue, then our role is to enforce the statute according to its terms. Connecticut Dept. of Social Services, DAB No. 1982 (2005). The meaning of statutory language "cannot be determined in isolation, but must be drawn from the context in which it is used." Deal v. United States, 508 U.S. 129, 132 (1993).

Virginia asserts that the "plain meaning" of the term "hospital services" encompasses the care provided by physicians, and that a hospital's uncompensated costs of furnishing those services to hospital patients "are exactly the kinds of costs that Congress intended the DSH program to cover to assure continued access to hospital services for indigent patients." Va. Br. at 28-29; Reply Br. at 8. We disagree with this expansive interpretation. Although the services of physicians are often provided *in* hospitals and might reasonably be considered a subset or component of hospital services in that ordinary sense, the context surrounding section 1923(g) indicates that Congress intended the term "hospital services" to have a technical or specialized legal meaning.

The Medicaid statute describes a program in which participating states, pursuant to their state plans, make payments to hospitals, physicians, and other health care providers on behalf of program recipients for various categories of medical items and services. Section 1905(a)(1)-(18) of the Act specifies the categories of medical items and services that a state Medicaid program may, or in some cases must, pay for as "medical

assistance" under the state plan. "Inpatient hospital services," "outpatient hospital services," and "physicians' services" are listed in section 1905(a) as distinct categories of medical assistance.[6] Under longstanding regulations and agency program instructions, a state seeks federal reimbursement for its medical assistance expenditures by reporting them – by statutory service category – using the Medicaid Quarterly Statement of Expenditures (QSE). 42 C.F.R. § 430.30(c); 42 C.F.R. § 201.5(a)(3) (Oct. 1, 1987); State Medicaid Manual (CMS Pub. 45) § 2500 (instructions for completing and submitting the QSE).[7]

Unlike section 1905(a) of the Act, section 1923(g)(1)(A) refers to "hospital services" without labeling them as "inpatient" or "outpatient." However, a subsequently enacted DSH-related provision – section 1923(j) – clearly shows that Congress intended those labels to apply. Section 1923(j), enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2431, directs states to submit an independent audit verifying that "[o]nly the uncompensated care costs of providing inpatient hospital and outpatient hospital services . . . are included in the calculation of the hospital-specific limits under such subsection." Act § 1923(j)(2)(D) (emphasis added).

In addition, the Medicaid statute provides that a DSH payment (or "payment adjustment") constitutes an "appropriate increase in the rate or amount of payment" for "inpatient hospital services." Act § 1923(a)(1)(B). This statement suggests that Congress did not intend DSH payments to offset *all* of the costs that might be incurred by a DSH in addressing the medical needs of indigent patients, but only the costs of providing what might properly be classified as "hospital services" for Medicaid purposes.[8]

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[6] Act §§ 1905(a)(1) (inpatient hospital services), 1905(a)(2)(A) (outpatient hospital services), 1905(a)(5)(A) (physicians' services).

[7] The State Medicaid Manual is available on CMS's internet website at http://www.cms.hhs.gov/Manuals/PBM/list.asp.

[8] In Louisiana Dept. of Human Services, DAB No. 1772 (2003), the Board upheld CMS's determination that a hospital's costs of furnishing certain drugs to hospital outpatients were not costs of outpatient hospital services and thus could not be included in the calculation of the hospital's DSH payment limit. In support of that conclusion, the Board noted that language in

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In view of these circumstances, it is clear that the term "hospital services" in section 1923(g)(1)(A) refers to the categories of medical assistance identified in section 1905(a) as "inpatient hospital services" and "outpatient hospital services." By designating "hospital services" and "physicians' services" as separate categories of reimbursable medical assistance, Congress intended states to treat them as distinct for coverage, payment, and other program purposes. Thus, if a service is covered and paid for under the approved state plan as a "physician's service," it cannot simultaneously be recognized as a subset or type of "hospital service."

With this statutory framework in mind, section 1923(g)(1)(A)'s meaning is clear. A cost may not be included in the calculation of the DSH payment limit unless it is the cost of a service that is covered and paid for under the state plan *as a "hospital service*." As we explain in greater detail below, Virginia has presented no evidence that the physician costs at issue here relate to services that were (or could have been) covered and paid for by its Medicaid program as "hospital services." In fact, Virginia has acknowledged that the services in question, when provided to Medicaid recipients, were billed to Medicaid as "physicians' services." See Va. Ex. 83 (Oct. 16, 2003 memorandum from Sally Barber to Medicaid DSH File, at 4-5, submitted as Ex. 2 to Declaration of Sally Nan Barber).[9] Accordingly, we find

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[8](...continued)
the House Conference Report for the 1993 OBRA suggested that "Congress intended to *limit* the amount of funds that can be claimed as DSH payment adjustments for hospital services, rather than expand the types of medical assistance that can be claimed." DAB No. 1772, at 6 (italics in original). The Board also noted that acceptance of Louisiana's legal position would have permitted the hospital to include any reasonable drug cost in the payment limit calculation, even if the cost was not reimbursable by Medicaid as the cost of an outpatient hospital service, as long as the cost was incurred in connection with a hospital's outpatient treatment program. The Board found that this "would expand the scope of the DSH payment adjustment to make it a prescription payment plan for indigent patients, a result Congress likely did not intend." Id.

[9] We express no view about whether (or to what extent, if any) the statute permits a state Medicaid program to cover or pay for a particular service furnished by a physician as a "hospital service" rather than as a "physician's service." We emphasize
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considerable merit in CMS's request that we look no further than the statute to decide this appeal. But assuming that the statute's meaning is unclear with respect to the issue in this case, we conclude that the disallowance can be affirmed on the basis of a valid agency interpretation of section 1923(g)(1)(A).

Recognizing that Congress may have "failed to speak to the definition of hospital services with sufficient clarity," CMS urges us to accept the interpretation of section 1923(g)(1)(A) set forth it in its response brief. Response Br. at 11-12. As best we can determine, that interpretation, which CMS says is "consistent with the statutory design and longstanding regulatory policy," precludes a hospital from including physician costs in the DSH payment limit calculation *under any circumstances*. Id. at 11-20.

We decline to assess the reasonableness of that interpretation for two reasons. First, Virginia did not have timely notice of it. That interpretation of section 1923(g)(1)(A) appears nowhere in the Federal Register, program letters, or other sources of official agency policy. Indeed, as late as October 2003, after the OIG had completed its audit of UVMC and MCVH, CMS officials expressed the view that physician costs could be included in the payment limit calculation under some circumstances.[10] We thus decline to uphold the disallowance based on the interpretation of section 1923(g)(1)(A) contained in CMS's response brief. See Alaska Dept. of Health and Social Servs., DAB No. 1919 (2004) (When a statute's meaning is ambiguous or uncertain, we defer to the HHS operating division's interpretation of the statute as

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[9](...continued)
only that a service cannot be classified as both a hospital service and a physician's service.

[10] According to unchallenged accounts of an October 15, 2003 meeting between Virginia and CMS officials, CMS stated during that meeting that the cost of a physician's service could be included in the calculation of a hospital's DSH payment limit if the physician was a salaried employee of the hospital and the hospital customarily billed (and received the revenue) for the service. Va. Ex. 83 (Oct. 16, 2003 memorandum from Sally Barber to Medicaid DSH File, at 2-3; June 16, 2006 Declaration of Sally Nan Barber ¶ 3); Va. Ex. 82 (June 16, 2006 Declaration of Larry Fitzgerald ¶ 3). We note, however, that Virginia submitted no evidence that its teaching hospitals customarily billed Medicaid (or other insurers) for the medical services that faculty physicians furnished to hospital patients.

long as the interpretation is reasonable and the state or other grantee had adequate notice of that interpretation or, in the absence of notice, did not reasonably rely on its contrary interpretation.)

Second, this matter can be decided (as CMS alternatively contends) on the basis of the 1994 SMDL, upon which Virginia claims to have relied. Response Br. at 21-22; Va. Br. at 33. The 1994 SMDL is an official CMS interpretation of the relevant language in section 1923(g)(1)(A). In our view, the 1994 SDML timely and adequately notified Virginia that inclusion of physician costs in the hospitals' payment limit calculation would not be permitted in these circumstances.

Under the heading "Costs of Services," the 1994 SDML instructs a state to determine a hospital's uncompensated costs using the "definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under Medicare principles of cost reimbursement." Va. Ex. 61 (pg. 3 of summary) (emphasis added). Although the 1994 SMDL does not use the terms "inpatient hospital services" or "outpatient hospital services," it states that a hospital's "cost of services" includes both inpatient and outpatient costs. The terms inpatient and outpatient are used in the Medicaid statute and regulations only with reference to "hospital services" or "nursing facility" services (the latter category being irrelevant here). The 1994 SMDL further provides that, for purposes of section 1923(g)(1)(A), the determination of a hospital's allowable costs would be subject to the upper payment limit (UPL) regarding "institutional payment." In 1994, the relevant UPLs for "institutional" payment were caps on payments for "inpatient hospital services" and "outpatient hospital services." See 42 C.F.R. §§ 447.253(b), 447.272, 447.321 (Oct. 1, 1994).

From these elements of the 1994 SMDL, it should have been clear to Virginia, when it made the disallowed DSH payments, that a cost could be included in the calculation of a hospital's DSH payment limit only if it was an "allowable" cost (for payment or reimbursement purposes) of an inpatient hospital or outpatient hospital service under the state's Medicaid program or relevant Medicare cost reimbursement principles. These criteria are consistent with the flexibility that states have to determine the scope of covered services and to choose the methods for paying health care providers for those services. See 42 C.F.R. Part 447, subparts C & F; 42 C.F.R. § 440.20(a)(4) (stating that a Medicaid agency "may exclude from the definition of 'outpatient hospital services' those types of items and services that are not

generally furnished by most hospitals in the State"); Oklahoma Dept. of Human Services, DAB No. 1575 (1996). We agree with Virginia that the 1994 SMDL does not categorically prohibit a hospital from including physician costs in its payment limit calculation. But the 1994 SDML does not unconditionally authorize the inclusion of such costs either. The 1994 SMDL clearly advised Virginia that a cost could be included in the payment limit calculation only if was, or could be regarded as, an allowable cost of an inpatient hospital or outpatient hospital service.[11]

Virginia makes no claim — and we see no basis for one – that the 1994 SMDL is an unreasonable interpretation of section 1923(g)(1)(A). In describing section 1923(g), the House Conference Report for the 1993 OBRA states that the amount of a hospital's annual DSH payments would be limited to costs incurred by the hospital in furnishing "inpatient or outpatient services, less payments from Medicaid" (other than DSH payments) and less payments from uninsured patients. H.R. Conf. Rep. No. 103-213, at 835 (1993), reprinted in 1993 U.S.C.C.A.N. 1088, 1524. To calculate the DSH payment limit using this formula, a hospital must account first for the Medicaid "payments" it actually receives for "inpatient and outpatient services." Those payments would, of course, be for services that the hospital has billed to Medicaid as "inpatient hospital" or "outpatient hospital" services. Because Medicaid payments for covered hospital services operate as a baseline for calculating the DSH payment limit, and because the ostensible purpose of DSH payments is to supplement what DSHs receive for covered hospital services based on Medicaid's standard payment rates for those services, it is reasonable to suppose that Congress used the term "hospital services" in section 1923(g)(1)(A) to refer only to services that could be covered and paid for under Medicaid *as inpatient hospital or outpatient hospital services*.

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[11] CMS regulations contain definitions of various medical assistance categories, including definitions of inpatient hospital and outpatient hospital services. See 42 C.F.R. § 440.10, 440.20. Those definitions may limit how a state Medicaid program may define the scope of an inpatient hospital or outpatient hospital service for coverage, payment, or other program purposes. There is no need for us to discuss those limits because there is no evidence that Virginia's Medicaid program regarded the physician costs at issue here as allowable costs of inpatient hospital or outpatient hospital services.

Virginia's contention that the teaching hospitals properly included uncompensated physician costs in determining their DSH payment limits is untenable under the 1994 SMDL. There is no evidence in the record, or an allegation by Virginia, that the disputed physician costs were regarded as allowable costs of inpatient or outpatient hospital services under the State plan or under some other definition of allowable cost utilized by Virginia in administering its Medicaid program. The only portions of the State plan in the record are two State plan amendments, SPA 96-02 and 97-18, which specify the criteria and methods used by Virginia to set Medicaid payment rates for "inpatient hospital services" provided in general acute care hospitals and rehabilitation hospitals during SFYs 1997 and 1998.[12] Nothing in these amendments indicates that Virginia's payment rates for inpatient hospital services were developed to compensate UVMC and MCVH for the costs of medical services furnished to hospital patients by faculty physicians. Va. Ex. 83 (Oct. 16, 2003 memorandum from Sally Barber to Medicaid DSH File, at 5 (indicating that Virginia's Medicaid program did not pay for physician services furnished to a Medicaid inpatient as part of the hospital payment rate)). In addition, there is no evidence that, for Medicaid payment or cost reimbursement purposes, UVMC and MCVH included the costs of faculty physicians on their Medicaid cost reports.[13] Furthermore, evidence submitted by Virginia indicates that the physician costs at issue relate to professional services that, when provided to Medicaid patients, were billed to Medicaid as "physicians' services." Id. at 4 (indicating the physician practice groups affiliated with UVMC and MCVH customarily billed Medicaid directly for the

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[12] Under SPAs 96-02 and 97-18, Virginia made prospective quarterly DSH payments that were calculated using a formula that accounted for the hospitals' Medicaid "ultilization rate" and projected "operating reimbursement." Va. Ex. 59, SPA 96-02, at 4-6; Va. Ex. 60, SPA 97-18, at 3-4. In addition to making these prospective payments, Virginia made "enhanced" DSH payments to UVMC and MCVH for fiscal years 1997 and 1998 after the hospitals submitted annual cost reports and Virginia verified the submitted cost data. Virginia Dept. of Medical Assistance Services, DAB No. 1838, at 5 (2002).

[13] SPA 96-02 and 97-18 state that Virginia "uses Medicare principles of cost reimbursement in determining the allowable costs for Virginia's reimbursement system," and that "[a]llowable costs will be determined from the filing of a uniform cost report by participating providers." Va. Ex. 59, SPA 96-02, at 22; Va. Ex. 60, SPA 97-18, at 17.

professional medical services rendered by its physicians to hospital patients).

Virginia contends that the physician costs were allowable costs of hospital services under the Medicare cost reimbursement principles set forth in 42 C.F.R. § 415.160. Va. Br. at 33-34. This Medicare regulation states that a teaching hospital "may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payment that might otherwise be made for these services." 42 C.F.R. § 415.160(a). The election is valid if the hospital notifies the Medicare intermediary in writing of the election and one of the following two circumstances exist: (1) all physicians who furnish services to Medicare beneficiaries in the hospital agree not to bill charges for their services; or (2) all physicians who furnish services to Medicare beneficiaries in the hospital are employees of the hospital and, as a condition of employment, are precluded from billing for these services. Id. If the hospital has made a valid election, the direct medical and surgical services of physicians at the hospital are "covered [by Medicare] as hospital services" and paid for on a reasonable cost basis in accordance with payment rules set forth in section 415.162. 42 C.F.R. § 415.160(c)(1), (c)(2).

The OIG determined that section 415.160 was of no help to Virginia because its teaching hospitals did not elect to receive reasonable cost reimbursement for its physician costs under the Medicare program. See, e.g., Va. Ex. 2, at 10. Virginia responds that no valid purpose would be served by requiring a hospital to elect reasonable cost reimbursement under Medicare in order to have physician costs included in the calculation of the Medicaid DSH payment limit, and that the 1994 SMDL did not require such an election in any event. Va. Br. at 34.

As noted, the 1994 SMDL expressly limits the costs that may be included in the calculation of the DSH payment limit to an amount that "would be allowable" as inpatient hospital or outpatient hospital service costs under Medicare principles of cost reimbursement. Va. Ex. 61 (pg. 3 of summary). Under section 415.160, the cost of a medical service furnished directly by a physician to a hospital patient would not allowable as the cost of a hospital service unless the hospital made a valid election to receive payment for that service on a reasonable cost basis. What seems critical here, in deciding whether a cost "would be allowable" under Medicare cost principles, is not whether the hospital actually elected to receive reasonable cost-based payment under Medicare but whether the hospital satisfied the critical regulatory conditions — having an agreement among all

physicians not to bill for services, or having all physicians be hospital employees who are precluded from billing as a condition of employment — for a valid election. Virginia has not alleged or shown that UVMC and MCVH satisfied those conditions.

Virginia has also failed to show that the hospitals calculated the physician costs using an appropriate methodology. As noted, if a valid election is made under section 415.160, the costs of a physician's direct medical and surgical services are treated as allowable hospital costs and reimbursed on a reasonable cost basis. 42 C.F.R. § 415.162(a). Virginia has not alleged that its teaching hospitals calculated their uncompensated physician costs using a reasonable cost methodology, nor has it shown that the amount of those costs included in the hospitals' payment limit calculations was a reasonable estimate of what Medicare would have paid the hospitals under that methodology.

Finally, Virginia contends that the payment limits for UVMC and MCVH were calculated in a manner authorized by Virginia's State plan. This contention rests on section I.D.2.e. of SPAs 96-02 and 97-18. Section I.D.2.e., entitled "OBRA 1993 § 13621 Disproportionate Share Adjustment Limit," states that "[n]o payments made [under the DSH payment adjustment formula in the previous section] shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 § 13621." Va. Ex. 59, SPA 96-02, at 5; Va. Ex. 60, SPA 97-18, at 4. Section I.D.2.e. then provides that DSH payments to a hospital during the fiscal year "shall not exceed the sum of":

> (i) Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year, and
>
> (ii) Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients.

Id. (emphasis added). Virginia contends:

> A plain reading of the State Plan demonstrates that its provisions do not discriminate regarding types of hospital costs and neither explicitly nor implicitly exclude medical care provided by faculty physicians. . . . In particular, the meaning of the phrase "costs incurred in serving persons who have no insurance" is plain and cannot reasonably be construed to exclude the

> cost of medical care provided at the hospitals by physicians if the hospitals incurred the cost — regardless of whether the physicians are employees of the hospitals or their related faculty practice plan or a combination of both.

Va. Br. at 24. Virginia further contends that, "absent a legitimate showing [by CMS] that . . . calculation of the [uncompensated cost] limits for UVA and VCU was inconsistent with the approved State Plan, section 1903(a)(1) of the Act prohibits CMS from retroactively disallowing federal matching funds for the DSH payments made under the State Plan." Id. at 25.

When the outcome of a dispute turns on a State plan provision whose meaning is ambiguous or uncertain, we defer to the state's interpretation of that provision "so long as that interpretation is an official interpretation and is reasonable in light of the language of the plan as a whole and the applicable federal requirements." California Dept. of Health Services, DAB No. 1474, at 3 (1994).

We see no evidence that, prior to making the disallowed DSH payments, Virginia officially adopted the State plan interpretation it now espouses. Connecticut Dept. of Income Maintenance, DAB No. 1435, at 6 (1993) (giving no deference to the state's interpretation of its Medicaid plan because the record contained no "contemporaneous, written official interpretation of the amended State plan, nor any evidence of a long-standing practice" consistent with that interpretation). Furthermore, that interpretation – which would permit a hospital to include a physician cost in the payment limit calculation as long as the hospital incurred the cost — is not reasonable. Section I.D.2.e. makes no mention at all of physician costs. That is no accident because SPAs 96-02 and 97-18 deal with payment standards and methods relating to "inpatient hospital services." As discussed earlier, nothing in SPAs 96-02 and 97-18 indicates that Virginia's Medicaid program treats the physician costs allegedly incurred by UVMC or MCVH as allowable costs of inpatient or outpatient hospital services.

In addition, Virginia's interpretation ignores applicable federal law and the context of the State plan provision at issue. Although the phrase "costs incurred in serving persons who have no insurance" is broad and appears to encompass any type of uncompensated cost incurred by the hospital in serving an indigent patient, the text of section 1923(g)(1)(A), relevant legislative history, and a valid agency interpretation of the statute (the 1994 SMDL, no mention of which is made in SPAs 96-02

and 97-18) collectively establish that only two categories of costs – allowable costs of inpatient hospital services and allowable costs of outpatient hospital services — may be included in calculating the DSH payment limit. The interpretation of section I.D.2.e. that Virginia advances here fails to acknowledge that federal requirement and would allow a state to circumvent the requirement by including in the payment limit calculation any type or amount of cost associated with a patient's hospital care.

Conclusion

For the reasons above, we affirm CMS's decision to disallow $11,085,181 in federal financial participation for the DSH payments made by Virginia to UVMC and MCVH for SFYs 1997 and 1998.

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy

/s/
Donald F. Garrett
Presiding Board Member