Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Illinois Department of Healthcare and Family Services
Request for Reconsideration of Decision No. 2863
Ruling No. 2019-1
January 17, 2019

RULING ON REQUEST FOR RECONSIDERATION

The Illinois Department of Healthcare and Family Services (Illinois) asks the Board to reconsider the decision in *Illinois Department of Healthcare and Family Services,* DAB No. 2863 (2018). The decision upheld the Centers for Medicare & Medicaid Services' (CMS's) disallowances of federal financial participation (FFP) in Medicaid disproportionate share hospital (DSH) payments to two hospitals for state fiscal years 1997 through 2000 on the ground that Illinois did not comply with its Medicaid State plan methodology for calculating and applying the DSH hospital-specific payment limits.

In its Motion for Reconsideration (Motion), Illinois argues that the Board erred in rejecting the State's interpretation of its Medicaid State plan because the Board did not read the State plan comprehensively or consider Illinois' intent and consistent administrative practice, as the Board's standards for construing state plan language require. Illinois also alleges that the Board made an error of fact in analyzing the State plan. Illinois submitted additional evidence to support its Motion.

For the reasons discussed below, we conclude that Illinois has not identified a clear error of law or fact in the Board's decision. We also conclude that the additional evidence proffered by Illinois is not the type of newly discovered or previously unavailable documentation that might justify reconsideration of a final decision. Accordingly, we deny Illinois' Motion.

Standard of Review

The Board may reconsider its own decision "where a party promptly alleges a clear error of fact or law." 45 C.F.R. § 16.13. In a case involving a Medicaid disallowance, a party has 60 days from the date of the Board's decision to request reconsideration. Social

Security Act (Act)[1] § 1116(e)(2)(B). The Board will not reconsider a decision "to address an issue that could have been raised before, but was not, or to receive additional evidence that could have been presented to the Board before it issued its decision, but was not." *Ruling on Request for Partial Reconsideration of DAB No. 2103, Alaska Dep't of Health and Soc. Servs.*, Ruling No. 2008-1, at 4 (2007).[2] The Board's "standard is similar to the one applied under Federal Rule of Civil Procedure 59(e), which authorizes a motion to alter or amend a judgment." *Id.* n.*. Rule 59(e) motions generally "are granted only to correct manifest errors of law or fact or to consider newly discovered or previously unavailable evidence." *Id.* (citing *Wright, Miller & Kane*, 11 Federal Practice and Procedure 2d § 2810.1).[3]

Background and Illinois' Motion

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) amended section 1923 of the Act by requiring states to impose hospital-specific caps on Medicaid DSH payments. Pub. L. No. 103-66, § 13621, 107 Stat. 312, 629-33 (1993). To implement the statute, Illinois submitted, and CMS approved, a state plan amendment (SPA) that read:

> Omnibus Budget Reconciliation Act of 1993 (OBRA '93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospital's disproportionate share payments shall be made if the sum of Medicaid payments (inpatient, outpatient, and disproportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. The adjustment to hospitals will be computed by determining a hospital[']s cost of inpatient and outpatient services furnished to Medicaid patients, less the amount paid to the hospital for inpatient and outpatient services excluding DSH payments made under this State plan. The cost of services provided to patients who have no health insurance or source of third-party payment less any payments made by these

[1] The current version of the Social Security Act is available at https://www.ssa.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. A cross-reference table for the Act and the United States Code is available at https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

[2] Available at https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2007/Ruldab2008-1.pdf.

[3] Although the Federal Rules of Civil Procedure are not controlling in the Board's review process, the Board has looked to the Rules and related cases for guidance. *E.g., Chateau Nursing & Rehab. Ctr.,* DAB No. 2427, at 8 (2011).

> patients shall be determined and added to the Medicaid shortfall calculated above. The result shall be compared to the hospitals estimated DSH payments. If the estimated DSH payments exceed the DSH limit (Medicaid shortfall plus cost of uninsured) then the Department will reduce the hospitals DSH rate per day so that their DSH payments will equal the DSH limit. If necessary, retroactive adjustments will be made.

State Plan Att. 4.19-A, at 53, ¶ 7.g.iv., IL Opening Br. Ex. 2.[4]

Illinois argues that DAB No. 2863 "turned on" whether the "last sentence of this paragraph" "required [Illinois] to reconcile DSH payments to the hospitals' actual uncompensated costs incurred by the hospitals in providing care to Medicaid beneficiaries and the uninsured, during the relevant time period." Motion at 1-2. Illinois contends that it never intended the sentence to require it to do so. Rather, Illinois says that "because the payments were prospectively set," it included the sentence in the event that a hospital successfully appealed the amount of its DSH adjustment or other Medicaid payments, and the hospital's increased payments "caused it to exceed the prospectively-calculated hospital-specific DSH cap." Motion at 2-3 (citing McCurdy Decl., ¶¶ 10, 11, IL Opening Br. Ex. 3). In that case, Illinois "wanted the flexibility to be able to retroactively modify the payment to stay within the cap." Motion at 3.

According to Illinois, the Board erred in rejecting this interpretation of the State plan by deviating from the Board's long-established approach to evaluating a state's proposed interpretation of its state plan. Illinois says that the Board was required to give effect to the language of the plan as a whole by reading its State plan "comprehensively," "as a single comprehensive document," and not reading individual provisions in isolation. Motion at 4, 6. Illinois alleges that the "Board has not previously focused on the specific language present (or missing) in each provision of the State Plan, but has instead attempted to understand the overall intent of the provision, and how separate provisions of the plan interact." *Id.* at 5 (citing *Missouri Dep't of Soc. Servs.*, DAB No. 1189 (1990)). Illinois further alleges that the Board failed to consider Illinois' intent and past administrative practices, which show that the state consistently interpreted and implemented the provision, in keeping with the interpretation advanced on appeal. Illinois contends that the Board's decision imposed a new requirement, "that the State had an obligation to more clearly communicate its intent to CMS." Motion at 4.

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[4] DAB No. 2863 cited to this provision based on its location in the record: Exhibit 2 to Illinois' Opening Brief, at internal page 53. For greater clarity and in order to fully address the arguments in Illinois' Motion, we include the paragraph designation of this provision as shown in the exhibit. We note that CMS's Brief in Opposition to Illinois' Motion states that during the relevant period, the paragraph was designated VI.C.7.f.iv and that an amendment approved in 2001 changed the designation from subsection f to subsection g. CMS Brief at 2 n.1.

Discussion

1. Illinois misconstrues the Board's standards for determining whether to defer to a state's interpretation of its Medicaid state plan.

Illinois's Motion does not accurately describe the Board's process for evaluating whether a state has complied with the terms of its Medicaid state plan. As noted in DAB No. 2863, federal regulations use the terms "comprehensive" and "comprehensively" to describe Medicaid state plans. DAB No. 2863, at 2, 8-9. Specifically, 42 C.F.R. § 430.10 provides that a Medicaid state plan is required to be "a comprehensive written statement," in that it must set out "the nature and scope" of the state's Medicaid program, give "assurance that it will be administered in conformity with the specific requirements of title XIX," the regulations implementing that title, and "other applicable official issuances," and contain "all information necessary for CMS to determine whether the plan can be approved to serve as a basis for [FFP] in the State program." Section 447.252(b), in turn, provides that a state "plan must specify comprehensively the methods and standards used by the agency to set payment rates" for inpatient hospital and long-term care facility services "in a manner consistent with §430.10 of this chapter." In other words, the State is responsible for ensuring that its plan provides sufficiently comprehensive information to make clear its methodologies.

In adjudicating a dispute about whether a state has complied with a particular payment methodology in its state plan, the Board is not, however, required to review the entire plan "comprehensively," as Illinois' Motion suggests. Indeed, the Board generally does not receive an entire state plan, and did not in this case, but rather reviews the parts of the state plan that the parties identify as relevant and submit for the record. In this case, the Board reviewed all parts of the State plan that Illinois and CMS chose to submit – and evidently Illinois did not believe that the entire plan was necessary to understand the relevant provisions. Nor does the Board ignore or gloss over the language in the state plan that establishes the methodology. To the contrary, the Board always looks first to the text – the specific language – of the state plan methodology and any related provision submitted by the parties. DAB No. 2863, at 9 (citing *South Dakota Dep't of Soc. Servs.*, DAB No. 934, at 4 (1988); *New Jersey Dep't of Human Res.*, DAB No. 2107, at 6-7 (2007)); *see also Missouri Dep't of Soc. Servs.*, DAB No. 1189, at 5-7 (1990). If the wording is clear, the Board will "apply the text according to its plain meaning." *New Jersey* at 6.

If state plan language is susceptible to more than one interpretation or silent about an issue, the Board will generally defer to a state's interpretation "if that interpretation is reasonable, is consistent with the purposes of the plan, and does not conflict with program requirements." *Texas Health and Human Servs. Comm.,* DAB No. 2176, at 3 (2008)

(citing *New Jersey* at 5; *Missouri*, DAB No. 1189, at 5); *see also South Dakota* at 4. In deciding whether a state's proposed interpretation is reasonable, the Board "will consider whether [it] gives reasonable effect to the language of the plan as a whole," but also recognizes that a "state's interpretation cannot prevail unless it is reasonable in light of the purpose of the provision and program requirements." *South Dakota* at 4. Similarly, in a case where the parties identified elements of the overall structure of the payment system as shedding light on the meaning and purpose, the Board considered whether the state's interpretation was reasonable in light of both the specific language of the relevant provisions and the organization of the plan. *Missouri*, DAB No. 1189, at 5.

"The Board will also consider evidence about the intent of the provision." *South Dakota at 4.* The Board will not defer to a state's interpretation of ambiguous language "unless it is reasonable in light of the purpose of the provision and program requirements." *Id.* The Board has also said that, lacking "documentary, contemporaneous evidence of intent," it "may consider consistent administrative practice as evidence" of whether the state "was applying an official interpretation of a plan provision or has advanced an interpretation only as an after-the-fact attempt to justify acting inconsistently with or simply ignoring its plan." *Id.*

2. The Board made no clear error of law or fact in evaluating whether Illinois complied with the terms of its Medicaid State plan.

Illinois also mischaracterizes the Board's analysis in DAB No. 2863. The decision did not depart in any way from the Board's longstanding practices in reviewing state plan provisions; nor did the decision simply turn on the wording of the last sentence in the State plan's DSH hospital-specific limit methodology. Rather, applying the principles for construing state plan language in this case, the Board first closely examined the full text of the State plan provision implementing the DSH hospital-specific cap statute. The decision described how the State plan language set out a multi-step methodology, which "required Illinois to compare a hospital's DSH limit to estimated DSH payments and to reduce the hospital's DSH rate in the event that 'the estimated DSH payments exceed the DSH limit. . . .'" DAB No. 2863, at 14 (quoting IL Opening Br. Ex. 2, at 53). Based on the directly applicable wording, the Board explained, the process that Illinois used to calculate and apply each hospital's DSH payment limit during the relevant period (as described in Illinois' opening brief and the written testimony of a State official submitted as an exhibit) could not reasonably be considered consistent with the State plan. No language in the methodology provided for Illinois to compute the hospital-specific DSH limits using the State's upper payment limit methodology as it did, based on inflated and adjusted 1992 and 1994 data. The decision also discussed why Illinois' reliance on a 1994 State Medicaid Directors Letter as support for its approach was misplaced.

Furthermore, the Board took into account other provisions in the State plan in concluding that Illinois violated the plain language of the State plan methodology by including unreimbursed costs of insured patients ("bad debt") in its DSH limit calculations. Specifically, the Board considered the DSH reporting provisions and the State plan definition of uncompensated care charges, on which Illinois relied to support its inclusion of unreimbursed costs of insured patients in its calculations of the DSH hospital-specific limits. After considering the provisions, the Board determined that they did not excuse Illinois from violating the plain wording of the State plan methodology, which "did not refer to 'uncompensated care charges,' but provided that only the unpaid 'cost of services provided *to patients who have no health insurance* or source of third-party payment less any payments made by these patients' would be included in the 'cost of uninsured' component of the hospital-specific limit." DAB No. 2863, at 13 (quoting IL Opening Br. Ex. 2, at 53 (emphasis in decision)).

The decision further described why Illinois' interpretation of the last sentence of the DSH hospital-specific limit provision was unreasonable in light of the specific wording of the sentence *and* when the sentence was read in context. DAB No. 2863, at 13-14. Most importantly, no language in the sentence or the paragraph mentioned hospital appeals, referenced the hospital appeal process, or otherwise supported Illinois' interpretation of the term "[i]f necessary" to mean only in the event of a successful hospital DSH payment appeal. The Board therefore read the "retroactive adjustments" provision in context, as referring to the preceding sentences of the provision, which stated that Illinois would compare a hospital's DSH limit to its estimated DSH payments and reduce the hospital's DSH rate in the event that "the estimated DSH payments exceed the DSH limit. . . ." *Id.* at 14 (quoting IL Opening Br. Ex. 2, at 53). Based on the wording of the sentence providing for "retroactive adjustments" to be made when "necessary," the language to which it referred, and the absence of any mention in the provision to the hospital payment appeal process, the Board concluded that Illinois' interpretation could not be considered reasonable. *Id.* at 14. Conversely, the Board determined, on its face and when read in context, the language "required Illinois to reconcile the estimated DSH payments to a hospital's actual Medicaid shortfall and 'cost of insured' and to make retroactive adjustments if necessary to ensure that DSH payments to a hospital did not exceed the hospital's applicable limit." *Id.*

Moreover, by pointing out that the hospital appeal provisions were in a different chapter of the State plan, the Board did not "suggest[] that DSH appeals are not referenced in the section regarding DSH adjustments" or read the DSH hospital-specific limit provision in isolation, as Illinois asserts. Motion at 6-8 (emphasis added). The decision in fact cited to the page of the DSH payment section that contained a reference to the hospital appeals procedures, and it was based on that reference that the Board surmised the appeals

procedures were set out in Chapter IX. DAB No. 2863, at 13 (citing IL Opening Br. Ex. 2, at 52). The purpose of noting that the appeals provisions were in a different chapter was to stress the lack of foundation for Illinois' interpretation: If a successful hospital payment appeal were the only basis for a retroactive adjustment to be "necessary," as Illinois argued, the organization of the plan would indicate how the "retroactive adjustments" provision was tied to the appeals process. Since the wording of the hospital-specific cap provision did not mention appeals, the alternative place to find language linking the processes or showing how they might be coordinated would be in the appeals provisions. Yet, those provisions were in a different chapter of the plan that Illinois did not even include with its submissions, indicating that there simply was no textual or organizational support for its interpretation of the "retroactive adjustments" provision.

Illinois now suggests that the Board should have deferred to its interpretation of the last sentence of the OBRA 1993 provision because "[o]nly one short paragraph . . . separates the reference" to the appeals procedures in Chapter IX and the "retroactive adjustments" language of the DSH hospital-specific limit methodology. Motion at 7. This argument would have us ignore the context in which the reference to the appeals procedures appears, paragraph 7.g.ii. That paragraph states that the "DSH status" of a hospital will not be affected by any other hospital's appeal of its ineligibility for DSH payment adjustments, or of its DSH payment adjustment amounts, "in accordance with Chapter IX." IL Opening Br. Ex. 2, at 52. Paragraph 7.g.ii does not set out the appeals procedures, refers only to maintaining DSH status, not to the calculation of DSH payments or limits, and does not in any way tie the appeals process to the "retroactive adjustments" language in the DSH hospital-specific limit methodology. Thus, the relative proximity in the State plan of a reference to the appeals procedures and the last sentence of the DSH hospital-specific limit methodology provides no support for Illinois' purported interpretation.

Illinois also argues that the Board failed to read the State plan as a whole because it "drew inferences from the State's use of the word 'retroactive' without giving due consideration" to evidence showing that the DSH hospital-specific limit provision did not use the same language that appeared in other sections of Illinois' State plan requiring retroactive reconciliation of payments to costs. Motion at 9-10. Illinois contends that the Board failed to take into account evidence showing that Illinois preferred to use prospective methodologies to pay hospitals, and almost always did so. Motion at 9-11. According to Illinois, the Board should have analyzed "the 'retroactive adjustment' language within the context of the State Plan as a whole, in which all hospital reimbursement is prospective unless expressly specified otherwise in detail . . . ." Motion at 11.

First, Illinois' general preference for using prospective payment methodologies to reimburse hospitals and its use of different language in other sections of its State plan when it "communicated its intent to reconcile payments to cost," Motion at 10, do not justify ignoring the specific language and context of the DSH hospital-specific limit methodology. As discussed in DAB No. 2863 and above, that language provided for a reconciliation of estimated payments to actual costs by requiring Illinois to compare a hospital's "DSH limit" to its "estimated DSH payments" and to make "retroactive adjustments" when "necessary." Moreover, as Illinois acknowledges, its State plan included other exceptions to the general use of prospective methodologies where specific policy considerations warranted. Such an exception was certainly called for in the case of the methodology implementing the DSH hospital-specific cap statute, the very purpose of which was to prevent states from making DSH payments that exceeded the hospitals' actual costs of providing medical care to the indigent and using the funds for other purposes. DAB No. 2863, at 2 (citing H.R. Rep. No. 103-111, at 211-12 (1993), *reprinted in* 1993 U.S.C.C.A.N. 378, 538-39).

Second, Illinois **did** use explicit language in specifying that retroactive adjustments will be made if necessary to DSH payments. What it did not do was provide any suggestion that only a single unusual event (a successful hospital appeal) could trigger the necessity to adjust retroactively. Thus, even under Illinois's claim that any use of retroactive methodologies in hospital payments will be expressly specified in detail, we would conclude that the express language should be applied as written and not expanded to add details not included in the provision.

Third, Illinois' reliance on the Board's decision in *Missouri Department of Social Services*, DAB No. 1189, is misplaced. That decision in part addressed whether Missouri's State plan permitted the State to grant trend factor increases to a provider's payment rates during the first year of the provider's operations. The Board determined that the language of the provision addressing new providers "did not specifically set forth trend factor formulas for newly constructed providers," but "implicitly recognized that such providers would receive trend increases" *Id.* at 6. The Board also found that CMS's reading to the contrary would create a permanent class of providers who would never obtain increased payments where all preexisting providers would obtain rate changes, and that CMS's proposed interpretation would be inconsistent with the entire payment methodology. Here, in contrast, Illinois' proposed interpretation: (1) contravenes the plan language, that retroactive adjustments would be made when necessary; (2) is not supported by the organization of the plan as a whole, which nowhere indicates that successful hospital appeals would be the only basis for retroactive adjustments to become necessary; and (3) is inconsistent with the purpose of adding the SPA -- to comply with the statutory mandate to limit DSH payments to **actual**, uncompensated Medicaid and uninsured patient costs.

3. The Board did not depart from its long-established standard for considering evidence of intent.

Illinois also argues that the Board erred by departing from its longstanding practice to look to evidence of a State's intent in determining whether a state's interpretation of its state plan is reasonable. Motion at 11, 14. "As in *South Dakota* and *New Jersey*," DAB No. 1090 (1989), Illinois says, it "submitted unrebutted testimony from a senior official" supporting the State's interpretation. Motion at 14. The official testified that Illinois consistently interpreted the "retroactive adjustments" provision as enabling "Illinois to adjust DSH payments if a hospital appealed for a higher DSH adjustment and won" and "never interpreted the State Plan language . . . as requiring the State to compare DSH payments to the hospitals' actual, [uncompensated] Medicaid and [uninsured] costs." *Id.* (quoting McCurdy Decl., ¶¶ 10, 11). Illinois further contends that contemporaneous communications with CMS in 1995 and 1996 show that Illinois informed CMS that it was using estimates in calculating the OBRA 1993 limit and that CMS approved the use of the estimates. The evidence of intent in its case, Illinois argues, was thus unlike the record in *Louisiana Department of Health and Hospitals*, DAB No. 2350 (2010), which also addressed whether State plan language implementing the OBRA 1993 limit required reconciliation of DSH payments to costs and to which DAB No. 2863 referred. Illinois additionally asserts that the Board erred by faulting it "for not more clearly specifying its intent regarding when a 'retroactive adjustment' might be necessary[.]" Motion at 16.

The importance of intent in evaluating a state's purported interpretation of its state plan arises only when there are two competing, reasonable interpretations of the language at issue or the state plan is silent with respect to the issue at hand. Where a state has advanced a reasonable interpretation of ambiguous language and there is no contemporaneous documentation of intent, the value of evidence demonstrating consistent administrative practice by the state is to distinguish an official, longstanding interpretation of the plan from an after-the-fact rationalization. To reach that question, the Board must first find that the state has offered an interpretation of the plan's language that reasonably reflects the terms of the provision at issue. In other words, the interpretation must plausibly address an ambiguity or gap in the wording which could have led each of the parties to have a different, good faith understanding of the meaning of the plan's language, and which does not contravene the purpose of the provision or other federal requirements.

These were the circumstances in the cases cited by Illinois where the Board determined that deference to the states' interpretations was appropriate. For example, in *New Jersey,* DAB No. 1090, the Board upheld the State's interpretation of language covering "non-medical" transportation services furnished under arrangement with the State Division of Public Welfare (DPW) to include services provided by the State Division of Youth and

Family Services, which had a written inter-agency agreement with the DPW. The Board reached its conclusion "taking into account all the circumstances," which included that the relevant language "was ambiguous enough so that the State reasonably construed it to permit such transportation, under the language of an arrangement with DPW," that "this was the State's consistent practice," and that the "costs were otherwise allowable." *New Jersey*, DAB No. 1090, at 2, 12-13. In *South Dakota*, the Board determined that the State's methodology for determining the number of patient days to be used in calculating the per diem rates for services reasonably interpreted ambiguous State plan language where the State presented undisputed evidence that, for every year but one, rates had not exceeded the facilities' actual costs, and the State's methodology related to a principle against which the figure could be objectively measured and which derived from the purpose of the provision. *South Dakota* at 5, 8-9.

In contrast, simply showing that the state failed to comply with the terms of its own state plan for an extended period cannot suffice to justify a claim that the state believed it could reasonably read the plan to suit its practice. That is the situation in which we find ourselves here. As described in the decision and summarized above, Illinois' purported interpretation is not reasonably supported by the wording of the State plan's hospital-specific cap provision. None of Illinois' arguments provides a reasonable basis to read into the requirement for making a retroactive adjustment "if necessary," a limitation to make a retroactive adjustment only if a hospital successfully appealed its DSH or other payment amount and, as a result of its increased payments, exceeded the previously-calculated DSH limit. Furthermore, as we have explained, Illinois' actual practices reveal that it failed to follow the plain language of the State plan's DSH hospital-specific limit methodology in other ways as well. For example, Illinois' inclusion of unreimbursed costs of insured patients in its DSH limit calculations expressly violated the plain language of the State plan methodology to include only the unpaid "cost of services provided to patients who have no health insurance or source of third-party payment less any payments made by these patients" in the "cost of uninsured" component of the hospital-specific limit. If anything, the fact that the State engaged in these other longstanding practices that plainly violated State plan provisions reinforces our conclusion that Illinois did not act on a good faith and reasonable contemporaneous interpretation of its State plan in the relevant regard either.

In addition, the record does not support Illinois' contention that "[c]ontemporaneous communications with CMS during the approval process for various 1995 State Plan amendments show that the State informed CMS that the OBRA 93 limit was calculated using '*estimates* for fiscal year 1996,' and that CMS approved the use of such estimates." Motion at 14-15 (citing IL Opening Br. Ex. 5, Letter from David Dupre to Robert Wright (Feb. 1996)) (emphasis added in Motion). The referenced February 1996 letter involved CMS's approval of SPA 95-14, not the amendment that implemented the hospital-specific

DSH limit provision, SPA 95-22. The letter summarized information that Illinois had provided to CMS in a November 17, 1995 letter, including estimated data for 1996 showing that the supplemental DSH payments to the University of Illinois at Chicago (UIC) Hospital would not exceed the OBRA 1993 limit. IL Opening Br. Ex. 4, at 2. Notably, CMS approved SPA 95-14 on February 16, 1996, many months before the end of the 1996 fiscal year, based on "the acceptability of the assurances" that Illinois had provided, including the "data indicat[ing] that total Medicaid inpatient payments to hospitals in State fiscal year 1996 will approximate 96.9% of allowable costs." IL Ex. 5, at 1. CMS also relied on Illinois' representation, based on its estimates for fiscal year 1996, that "the applicable DSH Limit" for UIC Hospital would "exceed[] DSH payments by $17.7 million." *Id*. at 2. While CMS thus approved SPA 95-14 based in part on Illinois' November 1995 estimates for fiscal year 1996, the approval did not excuse Illinois from retroactively adjusting DSH payments to actual costs to prevent the DSH hospital-specific limit from being exceeded.

Moreover, the Office of Inspector General (OIG) later found that Illinois had failed to follow its own methodology in estimating the hospital-specific limit for UIC Hospital for State fiscal year 1996. The OIG found that Illinois "inflated part of the Medicaid inpatient costs by more than 26 percent per year from 1992 to 1996, instead of a set 5 percent per year." Review of Illinois Medicaid Disproportionate Share Hospital Payments to the University of Illinois at Chicago Hospital, Oct. 2004, IL Opening Br. Ex. 7, at internal page 7. Had Illinois "correctly followed its own methodology," the OIG found, "it would have disclosed to CMS that payments to the hospital were estimated to exceed the hospital-specific limit by about $39.9 million for State fiscal year 1996." *Id.*

Illinois' attempt to rely on the differences in the State plan language and evidence of intent in its case and that of *Louisiana* to support its Motion also are unavailing. In *Louisiana*, the plain language of Louisiana's State plan established a retrospective system for making DSH payments under which the final, allowable payment amounts would be determined based on actual, audited costs. The Board also found in Louisiana's case that contemporaneous documentation in the record was at odds with the interpretation that Louisiana advanced on appeal. While it is true that the wording of Illinois' State plan and the record in its appeal differed from the wording of Louisiana's State plan and evidence in Louisiana's appeal, these differences do not justify reversing the disallowances in Illinois' case, where the State's purported interpretation of its State plan cannot reasonably be squared with the language that it chose to adopt or the purpose of the OBRA 1993 hospital-specific DSH cap.

Furthermore, we reject Illinois' characterization of DAB No. 2863 as "fault[ing] Illinois for not more clearly specifying its intent regarding when a 'retroactive adjustment' might be necessary," going "beyond prior Board decisions." Motion at 16. In support of this argument, Illinois relies on the Board decision in *South Dakota Department of Social Services*, DAB No. 934, discussed above, as well as the decisions in *Virginia Department of Medical Assistance Services,* DAB No. 1838 (2002), and *Missouri Department of Social Services*, DAB No. 1412 (1993).

The Board recognizes that states cannot be expected to include precise language in their state plans to address all conceivable payment issues that may arise in the administration of their Medicaid programs or to describe explicitly the purpose of each standard or methodology in their state plans. *See South Dakota* DAB No. 934, at 9 ("State plans are not as detailed as [CMS's] argument suggests they should be; nothing in the applicable federal provisions requires that the purpose of a provision be explained in the plan."). For these reasons, the Board developed and for decades has applied the procedures discussed above for evaluating whether to defer to a state's proposed interpretation where state plan language is ambiguous or silent. In the examples cited by Illinois, the state plan either was silent with respect to the issue raised on appeal (as in the case of the treatment of pharmacy copayments at issue in *Missouri*, DAB No. 1412), or ambiguous language in the plan was susceptible to more than one reasonable interpretation, including that proposed by the State (as in the case of the enhanced DSH payments at issue in *Virginia,* DAB No. 1838). The Board also determined in those cases that the state's proposed interpretations were consistent with the purposes of the program and did not result in a windfall in FFP to the state.

Here, in contrast, Illinois' purported interpretation cannot be considered reasonable in light of the directly applicable language of the State plan and would result in the type of windfall that Congress intended to preclude by enacting the OBRA 1993 hospital-specific cap legislation. Accordingly, Illinois is mistaken in arguing that the Board's decisions in other cases establish a clear error of law in DAB No. 2863.

4. We decline to consider the additional evidence submitted with Illinois' Motion.

Illinois' Motion alleges that the written declaration by a senior State official and other exhibits that Illinois previously submitted were "more than sufficient to support its position." Motion at 4. Nevertheless, Illinois proffered an additional exhibit (Exhibit 19) with its Motion, consisting of a second declaration by the same State official and five attachments (some of which are duplicative of its prior submissions) "to establish that the

Board's reading of the [State] plan was incorrect." *Id.* The additional documentation, Illinois says, "further explain[s] why the Board's decision does not give reasonable effect to the language of the plan as a whole, and does not comport with the State's consistent administrative practice*."* *Id.* at 6 n.2.

In order to ensure an orderly and efficient adjudication process, the Board's regulations at 45 C.F.R. Part 16 provide that it is the "appellant's responsibility" to submit to the Board an "appeal file containing the documents supporting the claim," that is, "those documents which are important to the Board's decision on the issues in the case." 45 C.F.R. § 16.8(a). Consistent with the regulations, the Board instructed Illinois and CMS, at the outset of Illinois' appeal, to "include all documents which would assist the Board in making findings of fact on disputed issues, as well as documents which provide necessary background information." Board Dkt. No. A-17-33, Acknowledgment of Notice of Appeal and Scheduling Order at 4; Board Dkt. No. A-17-34, Acknowledgment of Notice of Appeal and Scheduling Order at 4.

In light of the applicable regulations and instructions that the Board provides to the parties that appear before it, the Board will not reconsider a decision to receive additional evidence that could have been presented before the Board issued its decision, but was not. The Board has explained that a "motion for reconsideration is far too belated a context in which to undertake to present [additional] documentation," where the grantee "made no claim that this documentation was not available to it earlier in this process." Ruling on Request for Reconsideration of *Peoples Involvement Corp*., DAB No. 1967 (2005), Board Ruling No. 2005-2, at 2 (2005).[5]

In this case, the evidence submitted with Illinois' Motion was not the type of newly-discovered or previously unavailable evidence warranting reconsideration. The second declaration of Illinois' senior official, while dated after the Board's decision, consists of statements about Illinois' alleged understanding of the meaning of its State plan language and contemporaneous administrative practices during the relevant period, as well as arguments responding to the Board's decision. Furthermore, Illinois has not asserted that any of the documentation attached to the second declaration was newly discovered or previously unavailable. Accordingly, we decline to consider this evidence.

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[5] Available at https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2005/rul20052.htm.

Conclusion

For the reasons stated above, we deny Illinois' Motion for Reconsideration.

/s/
Susan S. Yim

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member