DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Missouri Department of Social Services
Docket No. A-07-124
Control No. MO/2007/001/MAP
Decision No. 2161

DATE: March 17, 2008

DECISION

The Missouri Department of Social Services (Missouri or State) appeals a disallowance of $36,200,000 issued by the Centers for Medicare & Medicaid Services (CMS). The disallowance involves community mental health center (CMHC) costs and supported community living (SCL) costs which Missouri included in calculating federal funding which it claimed under the Medicaid disproportionate share hospital (DSH) payment provisions for state fiscal year (SFY) 1999.

The federal Medicaid statute, codified 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 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 hospital-specific limit, or cap, on the amount of the annual DSH payment that may be made to any DSH. Each DSH's annual limit equals the "costs incurred . . . of furnishing hospital services . . . by the hospital" to persons who are eligible for Medicaid or who have no health insurance (or other source of third party coverage), net of any non-DSH Medicaid payments and payments received from uninsured individuals.

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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.

An audit finalized in 2002 by the Department of Health and Human Services' Office of Inspector General (OIG) found that Missouri's DSH claims for SFY 1999 were overstated because Missouri included CMHC costs and SCL program costs in the DSH payment limit calculations. The CMHC and SCL costs, the OIG concluded, did not represent "costs incurred" of "furnishing hospital services" under the statute. Based on the OIG's audit recommendations, CMS issued the disallowance determination appealed in this case.

The first issue presented in this appeal is whether Missouri properly included the uncompensated CMHC and SCL services costs in the calculations of the hospital-specific payment limits. Missouri submits that the CMHC and SCL services costs met the statutory criteria for inclusion in that they were "incurred" by the DSHs and were costs of "hospital services" within the meaning of section 1923(g)(1)(A) of the Act.

We conclude that CMS's determination that the CMHC and SCL services costs must be excluded from the hospital-specific DSH payment limit calculations is reasonable and entitled to deference. That the CMHC services were not "incurred" by the hospitals under section 1923(g)(1)(A) is supported by the plain meaning of the statute's text as well as its legislative history. In addition, CMS's determination that neither the CMHC services costs nor the SCL services costs qualified as costs of "hospital services" within the meaning of section 1923(g)(1)(A) represents a reasonable interpretation of the DSH statutes and relevant regulations, and was set forth in a 1994 letter to all state Medicaid directors (1994 SMDL).

We thus reject the State's contentions that the disallowance should be reversed on the grounds that the State reasonably relied on its own interpretation of the statute and was unaware of CMS's contrary interpretation. The plain language of the statute made clear that the CMHC services costs could not be included in the hospital-specific limit calculations and was binding on Missouri. In addition, the 1994 SMDL gave Missouri adequate notice that a cost could be included in the facility-specific payment limit calculations only if it was an "allowable" cost of an inpatient hospital service or outpatient hospital service. The CMHC and SCL costs were not recognized by Missouri's Medicaid program as allowable costs of outpatient hospital services, nor could they have been considered allowable hospital costs under Medicare cost reimbursement principles. Accordingly, for these and other reasons discussed below, we affirm CMS's determination that the CMHC and SCL services costs must be excluded from the calculations of the hospital-specific DSH payment limits.

The next question presented is whether the OIG and CMS properly calculated the disallowance amount. Missouri submits on appeal that there were significant errors in the OIG's calculations which resulted in an overstatement of the disallowance by nearly $15,000,000. Missouri argues that the OIG did not recognize that the SFY 1999 DSH payments were split between two federal fiscal years, FFYs 1998 and 1999. Further, because the State had not claimed FFP in the full amounts of the DSHs' uncompensated costs for each year due to other DSH program payment limitations, Missouri argues, further adjustments recognizing those limitations were necessary. Though CMS accepted one part of the State's argument, assenting to a reduction of the disallowance amount to $28,729,361, it neither accepted, nor provided a meaningful response to, the fundamental premise that the disallowance amount should recognize that the SFY 1999 DSH payments were split between the two federal fiscal years.

We conclude that, absent a meaningful response by CMS, the State has sufficiently demonstrated that the disallowance amount should be recalculated to recognize the State's allocation of the SFY 1999 DSH payments between the two federal fiscal years and to reflect the amount of FFP that the State could have claimed had it excluded the CMHC and SCL costs from its DSH payment calculations at the outset. We conclude that the total amount of the disallowance, properly recalculated, is $21,361,339.

Law and regulations

The federal Medicaid statute 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 sets 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 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 covered medical care under the state plan. Act §§ 1903(a), 1905(a). The Medicaid regulations include definitions of the categories of services that a state must, or in some cases may choose to, provide under the state plan. 42 C.F.R. Part 440.

A state Medicaid program pays for hospital services on the basis of payment rates that the state determines under its state plan. Act § 1902(a)(13); 42 C.F.R. §§ 447.201, 447.252(b). The rates for hospital services 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). Congress established the Medicaid DSH program in 1981, in response to findings 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.[2] Section 1923 of the Act imposes specific payment obligations on states with respect to DSHs. In particular, it requires state plans 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). A state may choose one of three formulas to calculate DSH payments. Act § 1923(c). In addition, section 1923(b) of the Act gives states considerable flexibility to designate which hospitals qualify for DSH payments.

In 1993, the Act was amended to require states to apply hospital-specific limits to DSH payments:

> 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 (as determined by the Secretary and net of 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

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[2] 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)).

> 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 (emphasis added). The House Budget Committee Report accompanying the legislation provided the following explanation of the impetus for, and purpose of, the amendment:

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

H.R. Rep. 103-111, 103rd Cong. 1st Sess. 211-12 (1993), reprinted in 1993 U.S.S.C.A.N. 378, 538-39 (emphasis added).

The Balanced Budget Act of 1997 (BBA) further amended the DSH statutes, adding subsection 1923(h) to the Act to restrict Medicaid DSH payments to state institutions for mental disease (IMDs). Pub. L. No. 105-33, § 4721(b), 111 Stat. 251, 513 (1997). A House Budget Committee report accompanying the BBA noted: "Our experience with the disproportionate share hospital program (DSH) tells us that sometimes the funds that Congress turns over to the states do not always reach the intended beneficiaries. Congress did not intend for DSH moneys to fund state psychiatric hospitals, or roads, or prisons, but in some states that is exactly what happened." H.R. Rep. No. 105-149, at 1647 (1997), 1997 WL 353017 (Leg.Hist.)(emphasis added).[3]

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[3] The Medicaid program prohibits FFP for the costs of inpatient services when they are provided to persons ages 22 through 64 who are patients of IMDs; in some circumstances, the exclusion also applies to individuals who are 21. Act §§ 1905(a)(1), 1905(a)(14), 1905(a)(16), 1905(a)(28)(B), 1905(h). This is generally referred to as "the IMD exclusion." The statute defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services." Act § 1905(i). States may, however, claim FFP for "inpatient hospital services for individuals 65 years of age or over in an [IMD]," and certain "inpatient psychiatric hospital services for individuals under age 21 [in IMDs]." Act §§ 1905(a)(14), 1905(a)(16), 1905(h). States may also receive FFP for the costs of inpatient hospital services furnished to psychiatric patients in non-IMD, general hospitals, as well as inpatient services furnished in institutions with 16 or fewer beds. The IMD exclusion codified Congress' belief that care in mental institutions was a traditional state responsibility, as well as Congress' general distrust of the effectiveness and efficiency of care in IMDs. New York State Department of Social Services, DAB No. 1577, at (1996) (citing S. Rep. 404, 89th Cong., 1st Sess., pt. 1 at 144 (1965), reprinted in 1965 U.S.C.C.A.N 1942, 2084-87; Schweiker v. Wilson, 450 U.S. 221, 242 (1980)).

In 2003, Congress increased state DSH auditing and reporting requirements under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2431. Describing the hospital-specific limits established under section 1923(g)(1)(A), section 1923(j) 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)(C) (emphasis added).

Although CMS has never issued regulations implementing section 1923(g)(1)(A) of the Act, in 1994 CMS sent a letter and attachment to all state Medicaid directors setting forth the agency's interpretation of the DSH payment limit provision. Mo. Ex. 11. The 1994 SMDL states that section 1923(g)(1)(A) "establishes facility specific limits on the amount of the payment adjustments that States may make to DSHs," and that "[t]he annual DSH payment adjustment to each DSH may not exceed the limit for that hospital." Id. (page 2 of summary). The 1994 SMDL also states that each DSH limit is calculated by adding: (1) the "[c]ost of [s]ervices to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan;" and (2) the "[c]ost of [s]ervices to [u]ninsured [p]atients, less any cash payments made by them." Id. (page 3 of summary). The 1994 SMDL then addresses what types of costs may be included in the calculation:

> 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. [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.

Case Background

The Missouri Department of Mental Health (DMH) is responsible for regulating, funding and providing public mental health services throughout the State. Mo. Ex. 27, at ¶3. In SFY 1999, DMH owned seven adult psychiatric hospitals. Id. at ¶5; Mo. Br. at 5. At the same time, DMH entered into contracts with, or designated, 28 CMHCs (22 privately owned and operated, and 6 State-owned and operated) as "administrative agents" to perform and administer an array of services for DMH clients. Mo. Ex. 21 at 4; Mo. Ex. 27 at ¶¶4, 15. (In some cases, CMHCs incurred these administrative duties by their affiliation with other contracted CMHCs.)

The services provided by the CMHCs included "diagnostic and treatment services, individual and group therapy, therapeutic activities, family counseling, patient consultation and education, rehabilitation services, screening services, and transitional living services [as well as] pre-admission screening and discharge planning services for the DMH inpatient hospitals." Mo. Ex. 27, at ¶6. The administrative agents entered into "Cooperative Inpatient Agreements" with the DMH hospitals in their service areas to delineate the responsibilities of each entity with respect to providing patient services and sharing information with each other. Mo. Exs. 9-10, 27, at ¶20. Beginning in 1995, Missouri included uncompensated CMHC services costs in the DSH payment limit calculations for those hospitals, usually recording the costs as "non-reimbursable cost centers" on the cost reports of DMH inpatient hospitals. Mo. Ex. 27, at ¶¶7, 25.

During the same period, DMH also ran an SCL program through its Comprehensive Psychiatric Services Division. Mo. Ex. 28. In most parts of the State, SCL staff provided community placement services and developed treatment plans for clients transitioning from inpatient care into "contracted housing arrangements." Id. at ¶¶3-4. SCL employees also "monitored the services the CMHCs provided to DMH clients" and provided "targeted case management and follow-up services to clients in these housing arrangements." Id. at ¶5 According to the State, "the SCL staff associated with a DMH hospital had offices at that hospital," and functioned "as the community placement office of the hospital." Id. at ¶6. Further, "[i]n most areas of the State, the SCL staff, like the other staff working . . . at the DMH hospitals, were directly employed by DMH" but "appointed by the hospital they served and . . . employees of the hospital." Id. A significant part of the SCL costs, including hospital-based SCL staff salaries, was paid

through the hospitals' budget allocations. Id. However, "certain additional direct and indirect costs associated with the SCL program, including fringe benefits for the SCL staff affiliated with the hospitals," were, according to the State, "incurred" by DMH's Central Office; they were not paid through the hospitals' budget allocations, but through separate line items in the State budget. Id. at ¶7.

In part of the eastern administrative region of the State, "DMH employees did not provide the full range of SCL services." Id. at ¶8. Rather, "employees of the private, non-profit contractors that operated the CMHCs" in certain areas provided "targeted case management and follow-up services for patients discharged from the hospitals." Id.

For the period at issue, DMH claimed the uncompensated costs of SCL hospital-based staff services and the indirect SCL costs "incurred by DMH Central Office" as hospital services costs under the DSH provisions, "usually recording the costs as 'non-reimbursable cost centers' on the cost reports." Id. at 9.

In August 2002, the OIG issued a final audit report concluding that the State's SFY 1999 DSH payments included overstated uncompensated care costs because DMH had included non-hospital CMHC and SCL costs in its DSH payment limit calculations. Mo. Ex. 21, at p. 4 of Report.[4] According to OIG, an overstatement of $36.2 million in federal funds was attributable to this error.[5] OIG wrote that the CMHC and SCL costs "represented costs of [DMH] and not uncompensated care costs of the State mental hospitals." Id. Supporting this conclusion, OIG reported statements by hospital officials at one of the State psychiatric hospitals that DMH "told the hospital what amount to report each year," and "[h]ospital officials believed the amount represented local area CMHC costs." Id. The OIG report also stated that the hospital officials indicated that the hospital did not record the

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[4] Missouri reviewed OIG's draft report of January 29, 2002 and responded to it by letter dated February 22, 2002. Mo. Ex. 19. The OIG's final report replied to the State's contentions. Mo. Ex. 21.

[5] According to the report, Missouri's overstatement had totaled $37.5 million FFP, which included $1.3 million attributable to a calculation error that was addressed in a separate audit report. Thus, the remaining $36.2 million, according to OIG, was attributable to the improper inclusion of CMHC and SCL costs. Mo. Ex. 21, at p. 4 of Report.

costs on its official accounting records and that the costs "were not for hospital services provided to patients of the hospital." Id. OIG further concluded that Missouri's Medicaid State plan did not permit the State to claim the CMHC and SCL costs as uncompensated care costs of hospital services incurred by the mental hospitals. Mo. Ex. 21, at p. 5 of Report.

CMS issued the December 14, 2005 disallowance at issue in this appeal based on the OIG audit report. Mo. Ex. 23.

Analysis

1. The CMHC services were not "incurred" by the hospitals and did not constitute "hospital services" under section 1923(g)(1)(A) of the Act.

We first address whether the CMHC costs that Missouri included in its SFY 1999 DSH hospital-specific payment limit calculations were "costs incurred during the year of furnishing hospital services . . . by the hospital[s] . . ." under section 1923(g)(1)(A) of the Act. The question of whether particular costs meet the statutory requirements of the payment limit provision may be broken down into two parts: 1) were the costs "incurred" by the hospitals; and 2) were the costs for "hospital services" within the meaning of section 1923(g)(1)(A). See Virginia Dept. of Medical Assistance Services, DAB No. 2084, at 8 (2007); see also Louisiana Dept. of Human Services, DAB No. 1772 (2003). To be included in the calculation of a DSH facility-specific payment limit, the costs must satisfy both requirements.

When addressing questions of statutory construction, we look first to the text of the law itself. United States v. Turkette, 452 U.S. 576, 580 (1981). If the text "clearly and precisely addresses the issue, then our role is to enforce the statute according to its terms." DAB No. 2084, at 8, citing 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). When a statute is subject to more than one interpretation, the courts have consistently held that they will defer to the interpretation of the federal agency charged with implementing the law if it is reasonable and not inconsistent with congressional intent. Chevron U.S.A., Inc. v. Natural Resources Defense Council, 467 U.S. 837, 842-43 (1984); Baptist Health v. Thompson, 458 F.3d 768, 773-74 (8th Cir. 2006); Pharmaceutical Research and Mfrs. of America v. Thompson, 362 F.3d 817, 821-824 (D.C. Cir. 2004). In general, the Board has held that where a statute is subject to more than one

interpretation, the Department of Health and Human Services operating division's interpretation is entitled to deference as long as it is reasonable and the grantee had adequate notice of that interpretation or, in the absence of notice, did not reasonably rely on its own contrary interpretation. Illinois Dept. of Children and Family Services, DAB No. 2062, at 8 (2007), citing Oklahoma Health Care Authority, DAB No. 1924, at 11 (2004) and cases cited therein.

a. The CMHC costs were not "incurred" by the hospitals.

With respect to the first requirement of section 1923(g)(1)(A) identified above, Missouri contends that the CMHC costs were "incurred" by the hospitals "in view of the relationships among the state hospitals, the CMHCs, and DMH." Mo. Br. at 22. Missouri acknowledges that DMH "incurred [the CMHC] costs by providing outpatient services through purchase from the CMHC's." Id. Yet, Missouri submits, "[t]he CMHCs and the hospitals were economically integrated, through DMH." Id. Consequently, Missouri submits, the CMHC costs effectively were "incurred by" the DMH hospitals. Mo. Reply Br. at 5. Moreover, Missouri argues, the CMHCs and DMH hospitals were clinically and contractually related by virtue of the types of services the facilities furnished, their frequent communications, the cooperative inpatient agreements into which they entered, and the administrative agent contracts between DMH and the CMHCs. In light of this integration of the entities, and because "the CMHC services were part of a continuum of inpatient and outpatient hospital services" offered by DMH, to deny FFP for the CMHC costs, Missouri argues, would elevate form over substance. Mo. Br. at 23.

CMS argues that the plain language of section 1923(g)(1)(A) compels the disallowance of FFP for the CMHC costs because the costs were not "incurred . . . by the hospital(s)" as the statute requires. The CMHC costs, CMS submits, were incurred by the CMHCs and paid as professional services under Missouri's Medicaid state plan. Moreover, CMS notes, Missouri itself acknowledges that the CMHC's were distinct entities that served as administrative agents of DMH, and that it was DMH, not the hospitals, that incurred the CMHC costs through purchase from the CMHCs.

Applying the standard for evaluating questions of statutory construction in this matter, we conclude that CMS's determination to exclude the CMHC services costs from the DSH payment limit calculations because they were not "incurred by the hospitals" is supported by the plain meaning of section 1923(g)(1)(a). The

common meaning of the word "incur" is: "1. To acquire or come into. . . . 2. To become liable or subject to as a result of one's actions; bring upon oneself." The American Heritage Dictionary of the English Language (Fourth Ed. 2000). Black's Law Dictionary defines "incur" to mean "[t]o suffer or bring on oneself (a liability or expense)." Black's Law Dictionary (8th Ed. 2004). Accordingly, to qualify as uncompensated DSH expenses under the first part of the two-prong test presented by section 1923(g)(1)(A), the costs must have been brought upon the hospitals as a result of the hospitals' actions.

In this case, the CMHC costs Missouri claimed were not brought upon, or attributed to, the hospitals as a result of the hospitals' actions. That is, the hospitals did not perform the services. Rather, the costs arose from the actions of DMH (which contracted with the CMHCs to perform the services) and the CMHCs themselves (which furnished the services based on their contractual obligations with DMH). The CMHC costs were not treated as costs for which the hospitals bore responsibility; they were merely recorded on the hospitals' Medicare/Medicaid cost reports as non-reimbursable cost centers, at the direction of DMH, in order to obtain DSH reimbursement for the CMHC services. Further, the hospitals and the CMHCs remained separate legal entities, notwithstanding their historic affiliations, the nature of the services provided, the administrative agent contracts, and the cooperative inpatient agreements.[6] That DMH owned and operated the hospitals and concurrently contracted with the CMHCs to provide the services did not transform the expenses into unreimbursed costs "incurred" by the hospitals within the plain meaning of that term. Nor does the history and "economic integration" of the entities provide a rationale that would permit the State to circumvent the plain meaning of the statute.

In addition, even if one concluded that section 1923(g)(1)(A)'s use of the word "incurred" were ambiguous (which we do not), the legislative history of the provision strongly supports CMS's literal interpretation of the term. The House Conference Report accompanying the 1993 OBRA, quoted at length above, shows that Congress enacted the amendment to "assist *those facilities* with high volumes of Medicaid patients in meeting the costs of

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[6] Missouri points out that historically many of the CMHCs were once actually part of the hospitals and were spun off and ultimately, in most cases, privatized. Mo. Br. at 7. If anything, this history highlights that the CMHCs are *not* now part of the State hospitals nor are their costs now incurred by the hospitals.

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." H.R. Rep. 103-111, 103rd Cong. 1st Sess. 211-12 (1993), reprinted in 1993 U.S.S.C.A.N. 378, 578-79 (emphasis added). Here, the CMHC costs that Missouri claims as falling within the DSH payment limit provision were not costs of the DSHs themselves, nor were they put to the purpose that Congress intended – to help safety-net hospitals offset *their* operating losses. Rather, DMH directed the hospitals to record the costs as non-reimbursable cost centers on the hospitals' Medicare/Medicaid cost reports so that it could obtain federal reimbursement for the uncompensated CMHC services, not uncompensated costs of hospital care.

As further reflected in the legislative history, Congress added the hospital-specific limit provision to the Act to prevent states from engaging in financing practices whereby they "made DSH payment adjustments to State psychiatric or university hospitals in amounts that exceed[ed] the net costs, and in some instances the total costs, of operating the facilities," and subsequently transferred some or all of the DSH funds to support non-Medicaid "public health or mental health services." Id. Thus, CMS's determination that Missouri may not claim and use federal DSH funds to reimburse costs that were not generated and sustained by the DSH hospitals themselves does not elevate form over substance, as Missouri contends. Rather, CMS's interpretation of the statute recognizes one of the fundamental purposes of the hospital-specific DSH limits, to prevent states from diverting federal DSH funds, intended to support safety net hospitals, to pay for an array of non-hospital, mental health and other services. See also Alaska Dept. of Health and Social Services, DAB No. 2103, at 27 (2007).[7]

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[7] In Alaska Dept. of Health and Social Services, the Board upheld CMS's determination disallowing FFP for DSH payments used to reimburse the costs of mental health clinic assistance (MHCA) services under Alaska's state plan and section 1923(g)(1)(A) of the Act. DAB No. 2103, at 25-30. Under Alaska's state plan, and consistent with the statute, a DSH could "qualify to receive a DSH payment by providing MHCA services through freestanding clinics." Id. at 27. However, the costs of the MHCA services could not be included in the calculation of the hospital specific limit because the DSH payments "were not retained by the hospitals to offset their DSH costs, but were passed through the hospitals and, at the State's direction,

(continued...)

We conclude that the CMHC services costs failed to meet the first requirement of section 1923(g)(1)(A).

b. The CMHC costs were not for "hospital services."

We next address why the CMHC costs also failed to meet the second requirement, identified above, of the hospital-specific payment limit provision. That is, the CMHC services costs do not qualify as "hospital services" costs within the meaning of the statute, relevant CMS regulations, or the 1994 SMDL.

Missouri argues that the term "hospital services" in section 1923(g)(1)(A) should be construed to include the CMHC services because of the nature of the services, the history of the CMHCs, the structure of the mental health services delivery network in Missouri, and the unique ties that the CMHCs have with the State psychiatric hospitals. The types of services furnished by the CMHCs are hospital services, Missouri writes, because they were previously furnished by hospital outpatient departments, and the CMHCs function as did the DMH hospital outpatient departments. In fact, Missouri submits, some of the CMHCs originated as DMH hospital outpatient departments, others started as satellite or traveling clinics operated by the hospitals, while others began as private, non-profit facilities. Mo. Br. at 6, citing Mo. Ex. 27 at ¶¶8-14. Regardless of their origins, Missouri argues, "all had close ties with the DMH hospitals." Mo. Br. at 6 (citing Mo. Ex. 27 at ¶¶19-24). Further, Missouri contends, the CMHCs were "administrative agents" of DMH or administrative agent affiliates of DMH and were responsible for coordinating the entry and exit of DMH clients into or out of the DMH network of care.

Missouri also contends that the 1994 SMDL, CMS's official interpretation of section 1923(g)(1)(A), supports the State's claims. The 1994 SMDL, Missouri writes, "explained that States could continue to define the 'cost of hospital services' broadly, in their State plans or otherwise, so long as they did not 'exceed the amounts that would be allowable under Medicare principles of cost reimbursement.'" Mo. Br. at 18, quoting 1994 SMDL. Missouri submits that its conclusion that the CMHC services were eligible for DSH reimbursement was consistent with its state plan. The State also argues that the CMHC services were "in the nature of 'outpatient hospital services'--that is, they [were] the types of services provided by hospitals." Mo.

[7](...continued)
disbursed to other entities to fund non-Medicaid costs." Id. at 29.

Br. at 21. Further, Missouri writes, services "typically provided by CMHCs can in some cases be counted as 'partial hospitalization' [services] under the Medicare program," which labels such services "outpatient services" and "reimburses CMHCs and hospitals for 'partial hospitalization services' via the same methodology." Mo. Br. at 19-21. Further, the State argues, although CMS has not "formally interpreted the term 'hospital services' in [s]ection 1923(g) to encompass its regulatory definitions of inpatient and outpatient hospital services in 42 C.F.R. Part 440," a recent statement by CMS in the *Federal Register* recognizes that the current regulatory definition of "outpatient hospital services" is so broad that it "does not clearly limit the scope of the outpatient hospital service benefit to those services over which the outpatient hospital has oversight and control." Mo. Br. at 21-22 (quoting 72 Fed. Reg. 55,158, 55,159 (Sept. 28, 2007)).

We reject Missouri's arguments. Section 1923(g)(1)(A) of the Act uses the term "hospital services," but does not define it or even label the services as "inpatient" or "outpatient." <u>See</u> DAB No. 2084, at 9. The House Conference Report accompanying the 1993 amendment, however, states that the amount of a hospital's annual DSH payment is limited to costs incurred by the hospital in furnishing "inpatient and 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), <u>reprinted in</u> 1993 U.S.C.C.A.N. 1088, 1524. Further clarifying the meaning of "hospital services" in section 1923(g)(1)(A), the subsequently-enacted section 1923(j)(2) of the Act references the DSH payment limit provision, directing states to submit independent audits verifying that "<u>[o]nly</u> the uncompensated care costs of providing <u>inpatient hospital and outpatient hospital services</u> . . . are included in the calculation of the hospital-specific limits . . . ." (emphasis added). DAB No. 2084, at 8-12. Together, these provisions establish that DSH payments are not meant to provide reimbursement for the costs of any service provided in or by a hospital, as might be thought from the ordinary sense of the term (hospital services). Rather, "the context surrounding section 1923(g) indicates that Congress intended the term 'hospital services' to have a technical or specialized legal meaning." DAB No. 2084, at 8. That is, the services that may be reimbursed through DSH payments and whose costs may be included under the limits are restricted to those properly identified as "inpatient hospital services" and "outpatient hospital services."

Consequently, we conclude that CMS reasonably reads the term "hospital services" in section 1923(g)(1)(A) to mean "inpatient

hospital services" or "outpatient hospital services" as those terms are generally used and defined in the Medicaid statute and regulations. Section 1905(a) of the Act includes "outpatient hospital services" among the categories of benefits that must, or in some instances may, be provided under a state Medicaid program. Act § 1905(a)(2)(A). Though the statute does not define the term, the regulations implementing the statute define "outpatient hospital services" at 42 C.F.R. § 440.20(a) to mean "preventive, diagnostic, therapeutic, rehabilitative, or palliative services" that–

> (1) Are furnished to outpatients;
> (2) Are furnished by or under the direction of a physician or dentist; and
> (3) Are furnished by an institution that–
> (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
> (ii) Meets the requirements for participation in Medicare as a hospital; and
> (4) May be limited by a Medicaid agency in the following manner: 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.

Section 440.2(a) of the regulations, in turn, defines "outpatient" to mean a "patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight."

Based on the criteria of 42 C.F.R. § 440.20(a), we concur in CMS's determination that the CMHC services at issue in this case do not qualify as "outpatient hospital services" for the purpose of calculating the hospital-specific DSH payment limits. Missouri has not established that all of the CMHC services were "preventive, diagnostic, therapeutic, rehabilitative, or palliative" services furnished by or under the direction of a physician or dentist. Further, the record indicates that the CMHC services were not furnished by institutions licensed or formally approved as hospitals, and which met the requirements for participation in Medicare as hospitals. Instead, the services were furnished by the CMHCs themselves, which are legally separate entities from the State psychiatric hospitals,

and which Medicare regulations define separately as entities that, among other things, "[m]eet applicable licensing or certification requirements for CMHCs in the State in which [they are] located." 42 C.F.R. § 410.2. Moreover, the record does not show that all of the CMHC services were furnished only to "outpatients" within the meaning of the regulations.[8] In sum, while Missouri characterizes a recent CMS statement about the regulatory definition of "outpatient hospital service" as "strongly suggest[ing] that the . . . definition . . . does not exclude services rendered by providers other than hospitals themselves, at locations other than a hospital campus," Missouri has not affirmatively established that the CMHC services in fact met the specific requirements of the regulation set forth above to qualify as Medicaid "outpatient hospital services." Mo. Br. at 22.

We also note that, while Missouri itself alludes to the current regulatory definition of "outpatient hospital services" to support its claims, Missouri simultaneously argues that the regulations at 42 C.F.R. Part 440 cannot be used to interpret the term "hospital services" in section 1923(g)(1)(A). Part 440 of the regulations, the State writes, interprets the term "medical assistance" at section 1905(a), for which states may receive FFP based on standard Medicaid payment rates. However, the State submits, the term "hospital services" in the DSH payment limit provision cannot be equated with the services listed at section 1905(a) because DSH payments are meant "to provide reimbursement . . . for costs that are otherwise not reimbursable through Medicaid or the State plan." Mo. Reply Br. at 4. Indeed, Missouri argues, section 1905(a) expressly excludes most IMD services from "medical assistance," while section 1923 of the Act separately provides for DSH payments to IMDs such as the DMH psychiatric hospitals. Thus, Missouri argues, "neither section 1905(a) nor regulations interpreting it can fully define the services reimbursable to IMDs through DSH payments." Mo. Reply Br. at 6.

Missouri's argument is unavailing. As noted above, section 1923(j)(2) of the Act establishes that the term "hospital services" in 1923(g)(1)(A) is limited to "inpatient hospital services" and "outpatient hospital services." The Act does not, however, separately define those terms under the DSH provisions.

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[8] In the DSH context, the outpatients may be "individuals who either are eligible for medical assistance under the State plan or have no health insurance," as provided under section 1923(g)(1)(A).

Consequently, the agency charged with implementing the statute may properly consider the context in which the DSH provisions were written and look to other sections of the Act and regulations that, though not directly linked to section 1923(g)(1)(A), may provide guidance as to the meaning of its terms. Thus, CMS reasonably relies on how section 1905(a) of Act categorizes different types of medical care that qualify as "medical assistance" under state Medicaid programs, as well as how CMS has defined the term "outpatient hospital services" by regulation, to determine whether the services at issue in this case may be reimbursed through DSH payments.

Furthermore, the DSH program was designed to recognize that standard Medicaid payment rates for inpatient hospital services do not fully reimburse DSHs for the costs of services furnished to Medicaid recipients and that these hospitals do not have other sources of income to offset fully their operating losses on Medicaid recipients and other low-income patients who have no health insurance. Thus, each hospital-specific payment limit reflects the sum of: (1) the "[c]ost of [s]ervices to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan;" and (2) the "[c]ost of [s]ervices to [u]ninsured [p]atients, less any cash payments made by them." Mo. Ex. 11 (page 3 of summary). The legislative history makes clear, however, that Congress did not intend the DSH program either to pay for a panoply of non-hospital public health and mental health services, or to provide an avenue for states to fully fund state psychiatric hospitals and thereby circumvent the Medicaid IMD exclusion. H.R. Rep. No. 103-111, at 211-12 (1993); H.R. Rep. No. 105-149, at 1647 (1997). In fact, the language in the 1993 OBRA House Conference Report suggests 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." Louisiana Dept. of Human Services, DAB No. 1772, at 6 (2003)(emphasis in original).[9] Thus, we reject Missouri's expansive interpretation of the term "outpatient hospital services costs," which would permit states to include in their DSH payment calculations the costs of any "type of services that the DMH hospitals did, and would have had to continue to, provide to outpatients if they were not provided by the CMHCs." Mo.

[9] In DAB No. 1772, 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.

Reply Br. at 5.[10] Such a definition would permit the State to use inpatient psychiatric hospitals as conduits through which the State could secure federal DSH funds and subsequently transfer those monies to support an array of mental health and other services that the DSH program was not designed to address, a result Congress clearly did not intend.

We also reject Missouri's claim that the 1994 SMDL authorized the State to include the CMHC services in the calculation of the DSH payment limits. As noted by the Board in Virginia, the 1994 SMDL does not use the terms "inpatient hospital services" or "outpatient hospital services," but it does provide that a hospital's "cost of services" for purposes of calculating the DSH limits includes both inpatient and outpatient costs. DAB No. 2084, at 12 (citing 1994 SMDL, p. 3 of summary). Nevertheless, the terms "inpatient" and "outpatient" appear in the Medicaid statute and regulations "only in reference to 'hospital services' or 'nursing facility' services (the latter category being irrelevant in the DSH context)." Id. In addition, "the 1994 SMDL 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.'" Id. at 12 (emphasis in original). Those principles, in turn, "are the general upper payment limit under institutional payment under the Medicaid program." Mo. Ex. 11, at 3.[11] "In 1994," the Board

[10] Missouri also submits that its understanding of the term "hospital services" in section 1923(g)(1)(A) is consistent with the Fifth Circuit's opinion in Louisiana Dept. of Health & Hospitals v. CMS, 346 F.3d 571, 576-578 (5th Cir. 2003). Missouri's reliance on that decision is misplaced. In Louisiana, the Fifth Circuit Court of Appeals reversed CMS's disapproval of a proposed state plan amendment establishing that uncompensated costs of providing health care services in rural health clinics licensed as part of rural hospitals would be considered outpatient hospital services costs for the purpose of determining DSH payments under Louisiana's Medicaid program. Id. at 576. Unlike the CMHC and SCL services involved in this case, the services described in Louisiana's state plan amendment, the court concluded, met the criteria (including the hospital licensing requirement) of section 440.20 of the regulations to qualify as Medicaid "outpatient hospital services." Id. at 577-579.

[11] A Medicaid upper payment limit (UPL) caps the amount,

(continued...)

continued, "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)." DAB No. 2084, at 12. Thus, the Board concluded, "under the 1994 SMDL, a cost may 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." Id.

In this case, the CMHC services costs were not recognized as allowable outpatient hospital services costs under Missouri's state plan, which, pursuant to the Act and Medicaid regulations, must specify the medical items and services covered by the state's program and establish the policies and methods used in setting payment rates. Act § 1902; 42 C.F.R. §§ 430.10, 447.201(b). According to the OIG audit report, Missouri's state plan included "a detailed description of the procedures and methodologies involved in determining what institutions receive DSH monies; what costs are included; how payments are computed; and the type of costs that can be included in uncompensated care costs . . . . [Yet,] there were no provisions in the plan that would allow claiming CMHC and [SCL] costs as uncompensated care costs of the mental hospitals." Mo. Ex. 21, at 5. While Missouri argues that its state plan "authorized DSH payments for inpatient and outpatient services based on 'base year charity care . . . charges multiplied by the base year cost-to-charge ratio,'" the cited provision does not establish that the CMHC services could be treated as outpatient charity care services or outpatient hospital services. Mo. Br. at 19, (citing State Plan, Attachment 4.19-A(VI)(D)(1)(d) at 11 (June 30, 1994)). Nor has Missouri pointed to any other provision in its state plan that either defines "outpatient hospital service costs" to include CMHC services costs or treats CMHC services costs as a subset of allowable outpatient hospital services costs.

We further find unpersuasive Missouri's assertions that the State used an alternative definition of "allowable outpatient hospital

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[11] (...continued)
in the aggregate, a state may pay to a group of providers for certain categories of medical services and still receive FFP. 42 C.F.R. §§ 447.257, 447.272 (Oct. 1, 1994). The UPL is a "reasonabl[e] estimate[]" of what "would have been paid for those services under Medicare payment principles." 42 C.F.R. § 447.272 (Oct. 1, 1994).

services costs" that included CMHC services costs; that such a definition was apparent in other documents; and that the allowable costs under that definition were not greater than the amounts that would have been allowable under relevant Medicare principles. Mo. Reply Br. at 7 (citing Mo. Ex. 12). The correspondence on which Missouri relies to show the State's use of an alternative definition of allowable outpatient hospital service costs is a 1995 letter from DMH to the fiscal intermediary discussing the State's intention to amend the DMH hospital cost reports to "include previously unreported costs for outpatient services . . . provided by [CMHCs]." Mo. Ex. 12. Notably, Missouri did not indicate in the letter that it had adopted an alternative definition of allowable outpatient hospital services costs, that the CMHC costs that it proposed to add to the cost reports actually reflected hospital services expenses, or that the proposed additions to the cost reports would be allowed under relevant Medicare hospital cost reimbursement principles. To the contrary, Missouri expressly stated in the letter that it was "not requesting reconsideration of Medicare rates or reimbursements." Id. (emphasis in original). Furthermore, the amended cost reports did not report the CMHC services costs as allowable outpatient hospital services costs, which would have been recorded in allowable hospital outpatient services cost centers. Instead, Missouri recorded the CMHC services costs as "nonreimbursable" cost centers, indicating that the State understood that the services would not be considered allowable hospital services costs under Medicare cost reimbursement principles.

Of additional importance, Missouri's claim that its Medicaid program recognized CMHC services costs as allowable outpatient hospital services costs is belied by how the State was actually billing and claiming CMHC services for Medicaid payment purposes during the period at issue. As evidenced by OIG audit workpapers, when a CMHC provided a covered Medicaid service to a Medicaid recipient, the service was claimed and paid under a professional service fee schedule, not as an outpatient hospital service. In the case of targeted case management and community psychiatric rehabilitation services provided by CMHCs, the services were not billed or claimed as "hospital services" or "outpatient hospital services," but billed as a separate type of service for purposes of obtaining FFP. CMS Br. at 15, n.4 (citing CMS Ex. 1). Thus, Missouri's argument that it had adopted an alternative definition of allowable outpatient hospital services costs to include the CMHC services costs is inconsistent with the State's contemporaneous actions during the period at issue.

We also reject Missouri's contention that the CMHC services costs in this case may be considered hospital services costs under section 1923(g)(1)(A), as interpreted in the 1994 SMDL, because they would have been considered allowable outpatient hospital services under relevant Medicare cost reimbursement principles. Missouri writes that "services typically provided by CMHCs can in some cases be counted as 'partial hospitalization services' under the Medicare program." Mo. Br. at 21. Further, the State submits, Medicare "reimburses CMHCs and hospitals for 'partial hospitalization services' via the same methodology." Mo. Br. at 19-20 (citing Act §§1832(a)(2)(j), 1861(ff)); 42 C.F.R. §§ 410.2, 410.43, 410.172); Mo. Reply Br. at 8. While certain services furnished by CMHCs may indeed qualify for Medicare payment as "partial hospitalization services" by meeting detailed criteria, Missouri has not demonstrated that the CMHC services costs at issue in this case would have qualified as Medicare partial hospitalization services costs under those criteria. Act § 1861(ff); 42 C.F.R. §§ 410.2, 410.43. Further, the Medicare regulations define a CMHC as "an entity that–(1) Provides outpatient services," not an entity that provides a type of outpatient *hospital* service. Even if partial hospitalization services could be considered outpatient hospital services when provided by a hospital, and even if the same "methodology" were used to reimburse outpatient partial hospitalization services provided by CMHCs, the CMHC's partial hospitalization services would still not have been incurred by the hospitals. For this reason, we need not inquire further whether any subset of the CMHC costs at issue here actually involved CMHC partial hospitalization services. Accordingly, we reject the State's reliance on the Medicare program's principles of payment for partial hospitalization services as supporting its treatment of the CMHC services costs in this case as allowable outpatient hospital services costs for the purpose of calculating the hospital-specific DSH payment limits.

We conclude that the CMHC services costs thus also failed to meet the second requirement of section 1923(g)(1)(A).

2. CMS reasonably disallowed FFP for SCL costs through DSH payments to DMH hospitals.

We next address whether CMS reasonably interprets section 1923(g)(1)(A) of the Act to bar the inclusion of the SCL services costs in the hospital-specific DSH payment limit calculations. Again, SCL costs would have to meet both statutory requirements, i.e., be "incurred" by the hospital and be for "hospital services," in order to be included in the DSH calculations.

With respect to the question whether the SCL services costs were "incurred" by the hospitals under section 1923(g)(1)(A), certain factors cited by the parties do not establish definitively that the SCL costs either were, or were not, "incurred" by the hospitals based on the plain meaning of the term. For example, the State submits that a "significant portion" of these costs was included in the DMH hospitals' budget allocations, and that where SCL staff were affiliated with particular hospitals, they were "regarded as hospital employees" and "essentially acted as the community placement office of the DMH hospitals." Mo. Br. at 27 (citing Vincenz Decl. Ex. 28 ¶¶4-6); Mo. Reply Br. at 10. The declaration of a DMH official, however, acknowledges that "DMH Central Office incurred certain additional direct and indirect costs associated with the SCL program, including fringe benefits for the SCL staff affiliated with the hospitals;" that "[t]hese additional costs [totaling $7,304,584] were paid not through the hospitals' budget allocations, but rather through separate line items in the State budget;" and that "[i]n five service areas in the Eastern administrative region of the State," employees of the private contractors that operated the CMHCs provided some of the SCL program services. Vincenz Decl. Ex. 28 ¶¶7-8. CMS argues that the SCL costs were incurred by DMH and not the hospitals because, according to the OIG audit report, the SCL costs "generally represented costs of State personnel that monitor and otherwise assist the mentally ill that live independently in the community" and because the "costs were not recorded on the hospital's official accounting records and were not for hospital services provided to patients of the hospital." CMS Br. at 22-23, citing Mo. Ex. 21, at p. 4.

While the parties thus present conflicting information as to whether all, or perhaps some part of the claimed SCL program costs were incurred by the hospitals within the meaning of the statute, we conclude that we need not resolve these factual differences because the SCL services costs were not costs of "hospital services" under section 1923(g)(1)(A). As discussed at length above, CMS has reasonably interpreted the DSH statutes as establishing that the term "hospital services" in the hospital-specific payment limit provision should not be read to mean *any* type of service that may be furnished by or in a hospital. Rather, the term has a technical or specialized legal meaning. Specifically, "hospital services" refers to services that are properly identified as either "inpatient hospital services" or "outpatient hospital services" as those categories of services are used generally in section 1905(a) of the Act. Further, outpatient hospital services reimbursable through DSH payments must satisfy the regulatory criteria of 42 C.F.R. §440.20(a), defining "outpatient hospital services" as "preventive,

diagnostic, therapeutic, rehabilitative, or palliative services" that are "furnished to outpatients;" that are "furnished by or under the direction of a physician or dentist;" and that are "furnished by an institution . . . licensed or formally approved as a hospital . . . meet[ing] the requirements for participation in Medicare as a hospital."

Based on the use and definition of the term "outpatient hospital services" in section 1905(a) of the Act and section 440.20 of the regulations, we conclude that the SCL services costs Missouri claims in this case do not qualify as outpatient hospital services costs that may be included in the calculation of DSH hospital-specific payment limits. The SCL services consisted of community placement services, assistance in the development of DMH clients' treatment plans, and monitoring or providing targeted case management and follow-up services for DMH clients in community housing. Nowhere has Missouri shown that all of these services were "preventive, diagnostic, therapeutic, rehabilitative, or palliative," nor has the State established that the services were furnished by or under the direction of a physician.

We further conclude that the 1994 SMDL interpreting section 1923(g)(1)(A) does not support Missouri's claim that the SCL services costs may be included in the calculations of the hospital-specific payment limits. Like the CMHC costs, the SCL services costs were not defined or recognized as allowable outpatient hospital services costs under Missouri's state plan. <u>See</u> analysis at section 1, <u>supra</u>. And, as we discussed above with respect to the CMHC services, Missouri has not established that the State used an alternative definition of "allowable outpatient hospital services costs" that included SCL services costs or that the costs would have been allowable under relevant Medicare principles. <u>Id</u>.

Accordingly, we affirm CMS's determination that the SCL services costs must be excluded from the calculations of Missouri's hospital-specific DSH payment limits.

<u>3. Missouri did not show that it reasonably relied on any alternative interpretation of the statute to include CMHC and SCL costs in its DSH payments to the DMH hospitals.</u>

Missouri submits that, even if the Board were to conclude (as we have above) that section 1923(g)(1)(A) of the Act does not permit the State to include the CMHC and SCL services costs in the hospital-specific payment limit calculations, CMS's disallowance should be reversed on the grounds that the State reasonably

relied on its interpretation of the statute and was unaware of the contrary agency interpretation. Mo. Br. at 24-27, citing Alaska Dept. Of Health and Social Servs., DAB No. 1919, at 13 (2004).

Most of Missouri's overarching contentions were also raised, and have been rejected, in relation to the specific CMHC and SCL costs. Here, we briefly address Missouri's more general assertions. The statute's language, the State submits, is convoluted, and CMS never issued regulations implementing the provision. Instead, CMS issued the 1994 SMDL, which the State understood to grant it broad flexibility to interpret the meaning of the statute's terms. According to Missouri, the OIG's position that a cost can be reimbursed by DSH payments only if the hospital itself actually provides, and incurs the costs for, the service is not compelled by the language of the statute. Mo. Br. at 25. Further, Missouri submits, CMS took inconsistent and inconclusive actions between 1996 and 1999 that did not put the State on notice that it could not claim reimbursement for the CMHC and SCL services costs through DSH payments.

We disagree with these assertions. For the reasons discussed in detail above, we have concluded that the plain meaning of the term "incurred" in section 1923(g)(1)(A) establishes that costs may be included in the calculation of DSH payment limits only if the costs are attributable to the hospitals' own actions - if the hospital provides the services and bears responsibility for those costs. Given the clear language of the statute, the State could not reasonably have believed that the CMHC services costs should have been included in the calculations of the DSH payment limits because these costs were not incurred by the hospitals themselves. Moreover, Missouri alludes to the Medicare principles that permit hospitals to obtain reimbursement for the costs of services they provide "under arrangement" with other entities and the costs of services offered by "provider-based" entities to support its belief that the CMHC services costs could be considered "incurred" by the hospitals in light of the clinical and contractual connections between the CMHCs and the hospitals. Mo. Br. at 25, citing Act at § 1861(w) and 42 C.F.R. §413.65. Yet, Missouri has not shown that the CMHC services at issue here were, in fact, furnished "under arrangement" with other providers or by "provider-based" entities within the meaning of the Medicare statutes and regulations.[12] Thus, we

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[12] Furthermore, in order to be considered provided "under arrangement" by a hospital, services must be of the kind (continued...)

also conclude that it was not reasonable for Missouri to have interpreted the hospital-specific limit provision to recognize the CMHC services costs as having been "incurred" by the hospitals for hospital services.

Further, the 1994 SMDL gave Missouri timely and adequate notice that inclusion of the CMHC and SCL services costs in the hospitals' payment limit calculations would not be permitted. While Missouri cites the 1994 SMDL statement that states would have "a great deal of flexibility" in determining the "cost of services" under section 1923(g)(1)(A), this flexibility was not without limits. Mo. Ex. 11, at 3. As discussed in detail above, other statements in the 1994 SMDL provided notice that a cost could not be included in the calculation of a hospital's DSH payment limit unless it was either an "allowable" cost (for payment or reimbursement purposes) of an inpatient hospital service or of an outpatient hospital service under the state's Medicaid program or relevant Medicare cost reimbursement principles. Because, as set forth in detail above, the CMHC and SCL services costs were neither "allowable" costs of outpatient hospital services under Missouri's Medicaid program nor allowable under relevant Medicare cost reimbursement principles, the State had adequate and timely notice that the costs at issue could not be used to calculate the hospital-specific payment limits.

Finally, we reject the State's assertion that other CMS actions "did not put the State on notice that it should abandon its interpretation of the statute." Mo. Br. at 25. As Missouri acknowledges, the Acting Associate Regional Administrator for Medicaid wrote to the Director of the Missouri Department of Social Services in March, 1996, stating that a preliminary assessment by CMS indicated that the State was erroneously including CMHC services costs in the State's DSH payment limit calculations for the DMH hospitals. Mo. Ex. 15. Missouri characterizes the letter as "suggesting that CMHC costs could not be included in the State's DSH payments because preadmission screening and discharge planning did not qualify as 'hospital services.'" Mo. Br. at 25, citing Ex. 15, at 2. "This suggestion," the State argues, "was in error, and CMS does not invoke such an argument now." Id.

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[12](...continued)
that a hospital is required to provide as part of its defined role as a hospital provider and must be billed by the hospital as its service (even though the hospital provides it by contracting for its delivery). Cf. Arizona Health Care Cost Containment System, DAB No. 1779 (2001).

We disagree with Missouri's characterization of the 1996 letter. CMS wrote in the letter that section "1923(g) of the Act limits the size of payment and allows the State to add in uncompensated costs associated with outpatient hospital service." Mo. Ex. 15, at 2. "However," CMS continued, "the admission screenings and discharge planning *being done by the CMHCs* do not meet the definition of inpatient or outpatient hospital services under 42 C.F.R. §440.10 and §440.20, respectively." Id. (emphasis added). Thus, CMS did not state that the reason the CMHC services should be excluded from the DSH payment calculations was that admission screenings and discharge planning would never be considered hospital services, as Missouri suggests. Rather, it appears that the basis for CMS's assessment was that *when the services were provided by the CMHCs,* the services were not allowable costs of inpatient hospital or outpatient hospital services, as defined by the Medicaid regulations at 42 C.F.R. §§ 440.10 and 440.20.

Furthermore, while CMS's delay between the issuance of the 2002 OIG audit report and the issuance of the disallowance determination is certainly unfortunate, it does not show, as Missouri claims, that "CMS did not have a clear view of how the statute should be interpreted and applied to CMHC costs," as Missouri suggests. Mo. Br. at 26. Nor does the delay provide a basis for ignoring the fact that the language of the statute, the 1994 SMDL, and the 1996 letter provided the State with timely and adequate notice that its own interpretation of section 1923(g)(1)(A) was unreasonable and inconsistent with CMS's interpretation of the statute. Accordingly, we conclude that Missouri's claim that the disallowance should be reversed on the grounds that the State reasonably relied on its interpretation of the statute when including uncompensated CMHC and SCL costs in its calculation of DSH payments is without merit.

4. The OIG and CMS erred in calculating the disallowance amount.

Missouri argues that, should we conclude that the disallowance relating to the CMHC costs and SCL costs was proper (which we do), we should revise the disallowance amount because the OIG auditors' calculations contained "significant errors." Mo. Br. at 28. First, Missouri submits, the calculations did not "take into account that the SFY 1999 DSH payment to DMH facilities was paid over two federal fiscal years." Mo. Br. at 30. Specifically, Missouri asserts, the auditors failed to recognize that, "while the *amount* of the State's DSH payments is based on costs in a state fiscal year (July 1 to June 30), the DSH payments are made and reported on a federal fiscal year basis (October 1 to September 30)." Mo. Br. at 28, citing Schneider Decl. Ex. 29 at ¶ 10 (emphasis in original). Consequently, one

quarter of the total SFY 1999 DSH amount was part of the DSH payments claimed at the end of the first state fiscal quarter, in September 1998 (FFY 1998), and the portion for the remaining three quarters of SFY 1999 was claimed in September 1999 (FFY 1999). Mo. Br. at 28-29. Missouri contends that the OIG auditors erroneously assumed that all of the SFY 1999 DSH payments were claimed and paid in FFY 1999. The proper allocation, Missouri submits, was a simple accounting step, not something that was part of the State plan methodology for determining DSH costs. Mo. Reply Br. at 11.

Furthermore, according to Missouri, the auditors' calculations did not properly take into account that the State had not claimed FFP in the full amount of its uncompensated DMH DSH costs for either FFY 1998 or FFY 1999 because: 1) in FFY 1998, Missouri had insufficient DSH allotment to claim the total amount due to DSH payments made to non-DMH hospitals; and 2) in FFY 1999, the total amount exceeded the separate IMD DSH cap created by section 1923(h) of the Act.

The State submits that the total amount of the first quarter of the SFY 1999 disputed DMH DSH payment was $15,578,623. Missouri contends that it reduced this amount by $7,213,433 because of the State's insufficient DSH allotment. Thus, Missouri submits, it actually claimed only $8,365,190 of the disputed CMHC and SCL uncompensated care costs for that period. Mo. Br. at 30-31. Further, Missouri argues, the State pointed this out in its comments responding to the OIG's draft audit report. Mo. Ex. 19, at 6-7. Yet, the OIG rejected the State's comments because, according to Missouri, the OIG did not realize that the first quarter of the SFY 1999 DSH payment was claimed and paid in FFY 1998. Mo. Ex. 21, at 6-7.

Missouri argues that while the OIG auditors attempted to take into account the IMD DSH cap in FFY 1999 to calculate the disallowance amount, the methodology they employed to do so was flawed. According to Missouri, the State's total DSH payments for the DMH facilities would have been $224,740,054, but for the separate IMD DSH cap of $199,562,749. Consequently, the State did not claim $25,177,305 in DMH uncompensated care costs in FFY 1999. The OIG auditors, assuming that all of the SFY 1999 DSH payment was included in the September 1999 FFY payment, "took account of the IMD cap by calculating that 11.2% of DMH's costs (*i.e.*, the ratio of $25,177,305 to $224,740,054) could not be claimed, and therefore reduced its calculation of the CMHC and SCL costs by 11.2%." Mo. Br. at 31 (citing Mo. Ex. 29 at ¶13; A-07-02089 at 4). The auditors then applied the 11.2% to their calculation of total SFY 1999 CMHC and SCL costs, producing an

estimated overpayment of $64 million, which was the basis for the disallowance. Missouri submits that this methodology was "patently incorrect" because it prevented the State from obtaining FFP for all of its allowable costs, not just a percentage of them. The auditors should have applied the amount of DSH costs the State could not claim because of the IMD cap against the unallowable CMHC and SCL costs included in the September 1999 DSH payment. This methodology, Missouri submits, properly recognizes that "the amount of the disallowance related to the September 1999 payment should be the difference between the amount the State could have claimed without the CMHC and SCL costs and the amount it did claim, or $29,192,155." Mo. Br. at 32, citing Mo. Ex. 29, at ¶14.

In sum, Missouri submits, to arrive at the proper disallowance amount, the auditors should have: recognized that the $69,948,062 in CMHC and SCL costs in DMH's SFY 1999 DSH payment was split between FFYs 1998 and 1999; accurately taken into account that the State had not fully claimed FFP in the full amount of its DMH uncompensated care costs for those years due to the amount of the State's DSH allotment in FFY 1998 and the IMD cap in FFY 1999; and applied the separate FMAP rates in effect in FFYs 1998 and 1999 for each year's payment amount.[13] Had these steps been taken, Missouri argues, the auditors would have concluded that the amount of FFP claimed for the CMHC and SCL costs for SFY 1999 was $22,661,339. Since $1.3 million of this amount was previously determined to be the result of a calculation error and was separately refunded, Missouri submits, the correct amount of the disallowance is $21,361,339.

In its response brief, CMS rejects Missouri's claim that the auditors' calculations should have taken into account that the SFY 1999 DSH payments were paid over two federal fiscal years. According to CMS, the OIG employed "the same methodology used by the State in calculating DSH costs" and "considered the State's 1999 claim for DSH payments as it was submitted by the

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[13] Missouri also describes how the disallowance amount is derived through use of the facilities' cost reports for SFY 1995, the application of facility cost-to-charge ratios to reported uncompensated care costs, and use of annual trend rates and growth factors to arrive at uncompensated care costs for subsequent years. Mo. Br. at 29-30. Missouri states that the auditors' workpapers and figures in the draft audit do not apply a cost-to-charge ratio calculation, though the final audit report states this was done. Id.

State. . . ." CMS Response Br. at 23. CMS, however, appears to accept Missouri's argument that the methodology used by the OIG to take into account the IMD DSH cap for FFY 1999 resulted in the State losing its opportunity to claim otherwise allowable costs. CMS therefore accepts, in principle, that the alternative methodology proposed by the State to account for the IMD DSH cap for FFY 1999 is "reasonable and fair." Id. at 24. Accordingly, CMS proposes to adjust the disallowance amount to $28,729,361.[14]

We conclude that Missouri's arguments that the OIG auditors erred in calculating the proper disallowance amount are reasonable and supported by the record. Missouri has provided detailed descriptions and documentation supporting its contentions that the OIG auditors' calculations were flawed, as well as documentation supporting the State's proposed revision of the disallowance amount. Mo. Ex. 29 (Schneider Decl. and Attachments A-C). With respect to the fundamental premise that the calculations should take into account that the SFY 1999 DSH DMH payments were split between two federal fiscal years, the State's assertions are cogent and well-documented. Id. Conversely, CMS replies only that the auditors used "the same methodology used by the State in calculating DSH costs," and that the auditors "considered the State's 1999 claim for DSH payments as it was submitted by the State." CMS Br. at 23. These comments are non-responsive. This calculation issue raised by the State does not go to the cost calculation methodology but to the assignment of the costs to the appropriate federal fiscal year. The State plan's description of the methodology for calculating uncompensated care costs did not have to spell out what the State aptly describes as "a simple accounting step" to reflect that the State and federal governments were using different fiscal years.

Further, CMS has provided no response to the State's contention that the first part of the SFY 1999 DSH payment disallowance should recognize that the State did not claim the full amount of DMH uncompensated care costs in FFY 1998 because of its insufficient DSH allotment. The State's argument is reasonable and well-supported by the documentation in the record. Mo. Ex. 29 (Schneider Decl. and Attachments A-C). Accordingly, in the absence of any response from CMS on this issue, we accept Missouri's calculations of the disallowance amount relating to the first quarter of SFY 1999.

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[14] CMS notes that its proposed revision to the disallowance amount "does not take into account the State's argument with regard to the cost-to-charge ratio because OIG took it into account," nor does it "take into account [the] $1.3 million calculation error" that was separately addressed and already refunded. CMS Br. at 25, n.7.

Finally, as noted above, CMS accepts the State's contentions that the methodology used by OIG's auditors to take into account the IMD DSH cap for FFY 1999 resulted in the State losing an opportunity to claim otherwise allowable costs, and that the alternative methodology proposed by the State to account for the IMD DSH cap for FFY 1999 is "reasonable and fair." CMS Br. at 24. Since the State has sufficiently documented the disallowance amount for the portion of DMH DSH costs properly allocated to FFY 1999, we accept the State's revised calculation of the disallowance amount for the final three quarters of SFY 1999.[15]

Accordingly, we conclude that CMS erred in calculating the disallowance amount in this matter, and we revise the disallowance to $21,361,339.

Conclusion

For the reasons above, we affirm CMS's determination to disallow FFP for SFY 1999 CMHC and SCL uncompensated costs claimed by Missouri pursuant to the DSH provisions of the Medicaid Act. We revise the amount of the disallowance to $21,361,339.

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan
Presiding Board Member

[15] We further note that Missouri's calculations of the final revised disallowance amount reflect the use of properly applied facility cost-to-charge ratios to the SFY 1995 uncompensated charity care charges, annual trend rates and growth factors for subsequent years, and the FMAP rates in effect for FFYs 1998 and 1999.